Army Regulation 608–18

Personal Affairs

The Army Family Advocacy Program

Headquarters
Department of the Army
Washington, DC
1 September 1995

Unclassified

SUMMARY of CHANGE

AR 608–18
The Army Family Advocacy Program

This revision--

- Implements the transfer of proponent responsibility for this regulation from the Office of the Deputy Chief of Staff for Personnel to the Assistant Chief of Staff for Installation Management.

- Authorizes the Assistant Chief of Staff for Installation Management to approve exceptions to this regulation.

- Updates DA policy on child abuse and neglect and spouse abuse.

- Clarifies Office of the Surgeon General (OTSG) responsibilities to include FAP in the Army medical budgeting and policy process (para 1-6).

- Requires unit commanders to provide written nonconcurrence with Case Review Committee’s (CRC) treatment recommendations (para 1-7b).

- Requires medical commanders to ensure use of Standards of Care (Appendix B).

- Deletes suicide prevention training for family members from the FAP.

- Creates two family advocacy teams: Replaces the FACMT with a smaller Case Review Committee (CRC) to review and assess all reports of abuse. An installation level Family Advocacy Committee (FAC) will address family advocacy program issues. The FAC is chaired by the installation’s Garrison Commander or designee (paras 2-3, 2-4).

- Clarifies rights advisement under provisions of Article 31, UCMJ by social workers (para 3-22).

- Consolidates DA guidance on reporting, prevention, treatment and investigation of out-of-home (institutional) abuse cases into one chapter(Chapter 8).

- Implements Department of Defense (DoD) Directive 6400.1, DoD Manual 6400.1-M, DoD Instructions 6400.2, 6400.3, and 1402.5.

Headquarters
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1 September 1995

*Army Regulation 608–18

Effective 30 September 1995

Personal Affairs

The Army Family Advocacy Program

By Order of the Secretary of the Army:

DENNIS J. REIMER
General, United States Army
Chief of Staff

Official:

JOEL B. HUDSON
Acting Administrative Assistant to the Secretary of the Army

History. This Update printing publishes a revision of this publication.Because the publication has been extensively revised the changed portions have not been highlighted. This publication has been reorganized to make it compatible with the Army electronic publishing database. No content has been changed.

Summary. This regulation contains the policies for handling spouse and child abuse within the Army. This regulation implements DoD Directive 6400.1, DoD Manual 6400.1-M, and DoD Instructions 6400.2, 6400.3, and 1402.5.

Applicability.

a. This regulation applies to members of—

(1) The active Army.

(2) The U.S. Army Reserve (USAR) on active duty training, or special duty for training, or special active duty for training (30 days or more duration).

(3) The Army National Guard of the United States (ARNGUS) on active duty for training, or special active duty for training under Title 10, United States Code (30 days or more duration).

(4) Other uniformed services (and their families) assigned to or residing on Army installations.

(5) And others entitled to care in medical treatment facilities(MTFs).

b. This regulation does not apply to members of the USAR performing inactive duty training or to members of the ARNGUS performing duty in a state status under Title 32, United States Code.

c. This regulation remains effective during mobilization.

Proponent and exception authority. The proponent of this regulation is the Assistant Chief of Staff for Installation Management (ACSIM). The proponent has the authority to approve exceptions to this regulation that are consistent with controlling law and regulation. Proponents may delegate the approval authority, in writing, to a division chief under their supervision within the proponent agency who holds the grade of colonel or the civilian equivalent.

Army management control process. This regulation is subject to the requirements of AR 11–2. It contains internal control provisions but does not contain checklists for conducting internal control reviews.

Supplementation. Supplementation of this regulation and establishment of command and local forms is prohibited without prior approval from HQDA(CFSC–FSA), Alexandria, VA 22331.

Interim changes. Interim changes to this regulation are not official unless they are authenticated by the Administrative Assistant to the Secretary of the Army. Users will destroy interim changes on their expiration dates unless sooner superseded or rescinded.

Suggested Improvements. Users are invited to send comments and suggested improvements on DA Form 2028 (Recommended Changes to Publications and Blank Forms) directly to Commander, U.S. Army Community and Family Support Center, ATTN: CFSC–FSA, Alexandria, VA 22331–0521.

Committee establishment approval. The Department of the Army Committee Management Officer concurs in the continuance of the Headquarters, Department of the Army and installation Family Advocacy Committee and Case Review Committees.

Distribution. Distribution of this publication is made in accordance with DA Form 12–09–E, block number 2535, intended for command levels A for Active Army, D for the ARNG, and C for the US Army Reserve.

Contents (Listed by paragraph and page number)

*This publication supersedes AR 608–18 dated 18 September 1987.

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RESERVED

Chapter 1
Introduction

Section I
General

1–1. Purpose
This regulation establishes Department of the Army (DA) policy on the prevention, identification, reporting, investigation, and treatment of spouse and child abuse. It also assigns responsibility for the Family Advocacy Program (FAP) in accordance with DOD Directive 6400.1, DOD Manual 6400.1–M.; and DOD Instructions 6400.2 and 6400.3 and DOD Instruction 1402.5.

1–2. References
Required and related publications and prescribed and referenced forms are listed in appendix A.

1–3. Explanation of abbreviations and terms
Abbreviations and special terms used in this regulation are explained in the glossary.

1–4. Policy
a. DA policy is to prevent spouse and child abuse, to protect those who are victims of abuse, to treat those affected by abuse, and to ensure personnel are professionally trained to intervene in abuse cases. Since many incidents of abuse constitute violations of the law, DA policy also recognizes a commander's authority to take disciplinary or administrative action in appropriate cases.

b. The FAP will promote public awareness within the military community and coordinate professional intervention at all levels within the civilian and military communities, including law enforcement, social services, health services, and legal services.

c. The FAP is designed to break the cycle of abuse by identifying abuse as early as possible and providing treatment for affected family members.

1–5. Objectives
The objectives of the FAP are to prevent spouse and child abuse, to encourage the reporting of all instances of such abuse, to ensure the prompt assessment and investigation of all abuse cases, to protect victims of abuse, and to treat all family members affected by or involved in abuse. In carrying out these objectives, the FAP will—

a. Provide installation commanders with staff assistance in addressing the problems of spouse and child abuse.

b. Provide information and education designed to support strong, self-reliant families and enhance coping skills.

c. Provide services to at-risk families who are vulnerable to the kinds of stresses that can lead to abuse.

d. Identify abuse as early as possible in order to prevent further trauma.

e. Provide treatment services to soldiers and their families involved in family violence in order to strengthen the family and prevent the recurrence of abuse.

f. Encourage voluntary self-referral through education and awareness programs.

Section II
Responsibilities

1–6. HQDA and MACOM responsibilities
a. Assistant Chief of Staff for Installation Management(ACSIM). The ACSIM has overall responsibility for policy guidance in implementing the FAP. The Commander, U.S. Army Community and Family Support Center (USACFSC) (CFSC–FSA), will perform the following functions for the ACSIM.

(1) Designate a FAP manager.

(2) Develop DA policy for ACSIM approval on the FAP.

(3) Develop and implement a needs assessment and program evaluation system to determine and monitor the use of resources, and report on program efforts.

(4) Submit FAP resource requirements through budget channels.

(5) Ensure compliance with DoD quality assurance standards(DoD Manual 6400.1–M).

(6) Provide policy and guidance for operating and maintaining the Central Registry.

(7) Work with the U.S. Army Training & Doctrine Command (TRADOC), The Judge Advocate General (TJAG), and individual Army schools to ensure adequate instruction is included in medical, dental, law enforcement, legal, and social service programs of instruction.

(8) Serve as Executive Agent for the Department of Defense (DoD)sponsored Family Advocacy Staff Training (FAST) Course. The FAST is a joint Service, multidisciplinary training course for entry level FAP staff conducted several times per year. Oversight rests with the DoD Family Advocacy Committee's Training Subcommittee. The Army's FAPM provides operational management and funds Army participants to the course.

(9) Fund and monitor the DA sponsored advanced Family Advocacy Staff Training courses which are taught several times per year to include specialized training for law enforcement and legal personnel.

(10) Sponsor training workshops for major Army command (MACOM) and installation personnel.

(11) Visit, monitor, and provide technical assistance to MACOMs and installations.

(12) Develop program materials.

(13) Establish and chair a multidisciplinary HQDA FAP Committee.Members include representatives from USACFSC; Office of the Deputy Chief of Staff for Personnel (ODCSPER); Office of the Surgeon General (OTSG); U.S.Total Army Personnel Command (PERSCOM); Office of the Judge Advocate General(OTJAG); Chief of Chaplains; Department of Defense Dependent Schools (DODDS);Security Force Protection and Law Enforcement Division, Office of the Deputy Chief of Staff for Operations and Plans (DAMO–ODL); U.S. Army Criminal Investigation Command (USACIDC), and the U.S. Army Drug and Alcohol Operations Agency (USADAOA), and Child and Youth Services, CFSC. The committee's purpose is to provide advice on FAP policy and promote related training.

(14) Designate nominees to represent Army on the DoD Family Advocacy Command Assistance Team (FACAT), ensure personnel are trained, and are released from normal duty assignment while deployed with the Team.

(15) Ensure individuals selected to serve on the DA Family Advocacy Regional Rapid Response Team are properly trained and are released from normal duty assignment while deployed.

b. The Deputy Chief of Staff for Personnel(DCSPER). The DCSPER is responsible for—

(1) Providing or designating a representative to the HQDA FAP Committee.

(2) Providing staff assistance in the formulation of FAP policy.

*c. The Surgeon General (TSG).*The TSG is responsible for coordinating medical resources and medical policies related to the FAP. The OTSG will—

(1) Ensure FAP intervention/treatment, manpower, and funding resources are programmed with AMEDD mission requirements.

(2) Provide a representative to the HQDA FAP Committee.

(3) Provide staff assistance informulation of FAP policy.

(4) Ensure that continuing and graduate medical education programs and positions exist to train necessary military physicians and medical service providers to staff the FAP.

(5) Ensure training for each health care provider serving as a member of the CRC including attendance at the DoD FAST, and other DA sponsored advanced training for FAP personnel.

(6) Coordinate medical pilot and research projects with USACFSC.

(7) Develop and implement an AMEDD FAP quality improvement program consistent with this regulation and DoD Manual (6400.1–M).

(8) Provide technical support to USACFSC in monitoring compliance with this regulation and DoD Instructions and Directives.

(9) Provide a representative to participate in CONUS and OCONUS technical assistance visits with USACFSC.

(10) Provide nominees to USACFSC to represent the Army on the DA Family Advocacy Regional Rapid Response Team and the DoD FACAT. Ensure personnel are released from normal duty assignment while deployed.

(11) TSG, through the U.S. Army Patient Administration System Biostatistics Activity (PASBA) is responsible for establishing and maintaining a central registry system (i.e., the Army Central Registry) for collecting and analyzing data on spouse and child abuse, including all resources and funding requirements necessary to operate the system. The function of the Central Registry is to track spouse and child abuse cases and to maintain a confidential Army-wide data base. The PASBA will—

(a) Record all reported spouse and child abuse cases and have this information available as required by law and according to regulation.

(b) Respond promptly while complying with Freedom of Information Act and Privacy Act requirements to authorized Case Review Committee (CRC)representative's requests for information on specific individuals or previously reported incidents of abuse.

(c) Forward a copy of the DD Form 2486(Child/Spouse Abuse Incident Report) to the child and spouse abuse reporting component of the appropriate service in all cases involving members of other military services and their families. DD Form 2486 is used to transmit case information to the Army Central Registry.

(d) Maintain information in the Army Central Registry according to AR 25–400–2, File No. 608–18 (Case Review Committee Team Files).

(e) Destroy all Central Registry identifying information pertaining to individuals after an installation CRC determines that an alleged spouse and child abuse case is unsubstantiated.

(f) Maintain a data base for Army-wide statistical information by compiling data on case loads, demographics, and trends for management and planning purposes. In this regard the Director, PASBA will—

1. Compile semi-annual reports as requested by the Commander, USACFSC and forward reports to USACFSC and major command points of contact(POCs).

2. Respond to DOD spouse and child abuse data collection requirements.

(g) Provide background checks on volunteers in Army Community Service (ACS) family advocacy programs, and on applicants, employees and volunteers in DoD sanctioned or operated activities and Department of Defense Dependents Schools (DODDS, and DODESS).

d. The Judge Advocate General(TJAG). TJAG will—

(1) Advise on legal issues involved in the FAP.

(2) Train and educate installation judge advocate officers in the legal issues involved in spouse and child abuse cases.

(3) Provide staff assistance in the formulation of FAP policy.

(4) Provide or designate a representative to the HQDA FAP Committee.

(5) Provide assistance to MACOMs and installations on the development of Memoranda of Agreements (MOAs) between Army installations and civilian social service agencies, law enforcement agencies, and the courts.

(6) Ensure the participation of judge advocate personnel at all levels of the FAP.

(7) When authorized, ensure there is a point of contact for, and serve as approval authority for, requests for soldiers, family members, civilian employees, and others to appear at Government expense as witnesses in state or local proceedings relating to domestic violence.

(8) Provide nominees to USACFSC to represent the Army on the DoD FACAT, and ensure personnel are released from normal duty assignment while deployed with the FACAT.

e. The Security Force Protection and Law Enforcement Division, DCSOPS (DAMO–ODL). The Chief, DAMO–ODL, DCSOPS will—

(1) Provide law enforcement policy and guidance for the investigation of spouse and child abuse.

(2) Provide a representative to the HQDA FAP Committee.

(3) Provide a copy of the Serious Incident Report(SIR) relating to child abuse in DoD sanctioned or operated activities to the Commander, U.S.Army Community and Family Support Center, (HQDA, ATTN: CFSC–FSA, Alexandria, VA 22331–0521).

f. Commander, U.S. Total Army Personnel Command (PERSCOM). The Commander, PERSCOM will—

(1) Coordinate the reassignment, deletion, and deferment of soldiers in appropriate FAP cases with USACFSC when a child or spouse is at risk of death or serious physical injury.

(2) Provide a representative to the HQDA FAP Committee.

g. The Chief of Chaplains. The Chief of Chaplains will—

(1) Provide specialized training for chaplains in identifying and addressing spouse and child abuse.

(2) Provide training, guidance and policy to sensitize unit ministry team members on the issues of spouse and child abuse, and the confidentiality of information obtained through privileged communications, particularly those chaplains participating on the CRC.

(3) Provide a representative to the HQDA FAP Committee.

*h. Other HQDA staff elements.*Other involved HQDA staff elements (e.g., CDS, YS, DODESS, Army Drug and Alcohol Prevention Control Program (ADAPCP), Public Affairs) will review pertinent regulations and staff training efforts and include information on spouse and child abuse and provide a representative upon request to the HQDA FAP committee.

i. Commanding General, U.S. Army Medical Command. The Commanding General, U.S. Army Medical Command will—

(1) Designate a FAP manager to manage and supervise the FAP treatment component to ensure compliance with this regulation.

(2) Provide medical, dental, and clinical FAP services.

(3) Provide the resources, professional services, and a quality improvement program required to support the FAP.

(4) Provide technical and professional guidance to medical treatment facility (MTF) commanders and designees regarding medical aspects of FAP to include establishing procedures, standards, and doctrine concerning the medical and dental aspects of identification, case management, treatment, and rehabilitation.

(5) Develop a standardized protocol for identification and management of abuse cases.

(6) Sponsor workshops and specialized training for physicians, dentists, and other clinical personnel on spouse and child abuse prevention, education, identification, case management, and treatment as needed and as funding permits.

(7) Analyze medical department activity (MEDDAC)and medical center(MEDCEN) budget submissions to formulate resource requirements. Submit program requirements through appropriate channels to USACFSC (CFSC–FSA).

(8) Allocate and distribute budget resources to MEDDACs and MEDCENS.

(9) Submit program personnel requirements through the total Army analysis process.

(10) Distribute authorizations and ensure assignment of staff for FAP.

(11) Conduct staff assistance visits and provide technical assistance to ensure care is consistent with program goals and mission.

(12) Establish a continuing medical education program for FAP personnel.

(13) Provide pertinent FAP data requested by USACFSC and OTSG.

(14) Provide nominees to the OTSG to serve as representatives to the DA Family Advocacy Regional Rapid Response Team and DoD FACAT. Ensure personnel are released from normal duty assignment while deployed.

(15) Coordinate all FAP related pilot and research projects with the OTSG and USACFSC.

(16) Publish a process to review CRC adverse determinations upon presentation of new information not previously known to the CRC at the time of initial presentation of the case or if there are

questions about the CRC's failure to comply with published protocols and requirements. Any recommendation made by this review body inconsistent with the initial finding of the CRC will be returned to the installation CRC for reconsideration. The local CRC has two options: if the CRC agrees with the MEDCOM review body, the CRC will submit a new DD Form 2486 indicating a changed finding; if the CRCdisagrees with the finding of the MEDCOM review body, the CRC will forward all relevant data/information to the HQDA FAC (CFSC–FSA) for final determination.

j. Commanders of Major Commands(MACOMS). MACOM Commanders will—

(1) Designate a FAP manager to supervise the overall operation of major subordinate command and installation FAPs to ensure compliance with this regulation.

(2) Monitor the major program elements of prevention, direct services, administration, evaluation, and training.

(3) Analyze subordinate command program reports and budget submissions to formulate resource requirements and evaluate installation program progress.

(4) Submit installation and MACOM program resource requirements through program and budget channels to USACFSC (CFSC–FSA), Alexandria, VA 22331.

(5) Allocate MACOM program resources to installations.

(6) Provide technical and professional guidance to include technical assistance and on-site evaluation to subordinate command and installation FAPS.

(7) Document training needs and sponsor training workshops for installation personnel as funding permits.

(8) Coordinate all FAP related pilot projects and research with HQDA(CFSC–FSA), Alexandria, VA 22331–0521.

(9) Disseminate semi-annual Army Central Registry statistical data to their major subordinate commands and installations.

(10) Ensure compliance with DoD quality assurance standards (DoD Manual 6400.1–M). Review subordinate command compliance documents and ensure completion of corrective action plans.

(11) Establish procedures in overseas commands for authorized civilians involved in spouse or child abuse to participate in treatment under the FAP and protect victims from further trauma.

(12) Report out-of-home abuse cases to higher command levels in accordance with Chapter 8 of this regulation.

(13) Provide nominees to the DoD FAST course, HQDA advanced courses for FAP personnel, DoD FACAT and HQDA Family Advocacy Regional Rapid Response Team as requested by USACFSC.

k. Commander, U.S. Army Criminal Investigation Command(USACIDC). The Commander, USACIDC will—

(1) Train USACIDC agents to investigate cases of child sexual and physical abuse through attendance at the DoD FAST course, advanced HQDA sponsored training, and the Child Abuse Prevention and Investigative Techniques course.

(2) Establish guidance and policy pertaining to the investigation of child sexual abuse.

(3) Ensure special agents specifically trained in interviewing victims of child sexual abuse are available to each installation.

(4) Investigate, through subordinate elements, cases of child physical and sexual abuse, and spouse abuse which fall within the investigative responsibility of USACIDC as established in AR 195–2, The Army Criminal Investigation Program.

(5) Provide a representative to the HQDA FAP Committee.

(6) Provide nominees to USACFSC to represent Army on the DoD FACAT and to the HQDA Family Advocacy Regional Rapid Response Team. Ensure personnel are released from normal duty assignment while deployed.

(7) Provide a copy of the initial and follow-up reports on all child abuse cases occurring in DoD sanctioned or operated activities within 24 hours of receipt to the Commander, U.S. Army Community and Family Support Center, (USACFSC–FSA), Alexandria, VA 22331.

1–7. Installation staff responsibilities

a. Installation commanders. Each Army installation commander will—

(1) Establish a program for the prevention, reporting, investigation, and treatment of spouse and child abuse as outlined in this regulation.

(2) Appoint an installation Family Advocacy Program Manager (FAPM) on orders to coordinate and manage the FAP, and to ensure compliance with this regulation.

(3) Designate a report point of contact (RPOC) and ensure a 24-hour emergency response system exists on the installation that is capable of providing immediate protection to victims of spouse and child abuse.

(4) Establish mandatory counseling and educational programs under the FAP for soldiers involved in spouse and child abuse.

(5) Establish voluntary educational and counseling programs under the FAP for, and establish procedures to encourage participation in these programs by—

(a) Civilian family members of soldiers involved in spouse and child abuse.

(b) Other civilians in overseas commands involved in spouse or child abuse who are entitled to care in MTFS. Civilians in this category may, but will not necessarily, include the following—

1. Appropriated and nonappropriated fund DA employees, their family members, and members of their households.

2. Retired soldiers and their family members.

3. Employees of DA contractors and their family members.

(6) Consider CRC recommendations when taking or recommending disciplinary and administrative actions with regard to soldiers and civilians involved in spouse or child abuse. Many of the considerations listed at paragraph 4-4 generally apply when taking disciplinary and/or administrative actions with regard to civilians involved in spouse or child.

(7) Direct the development of a MOA, whenever possible, with Child Protective Services (CPS) and other authorities in the civilian jurisdiction(s) adjoining the Army installation. (See paras 2-11 and 2-12 and figure C-1 for suggested contents and format of a MOA). The MOA should delineate each required responsibility and which installation agency is responsible.

(8) Appoint members of the CRC and FAC by written order and by name to serve as members for a minimum period of one year, subject to reappointment.

(9) Review CRC minutes.

(10) Establish ongoing training to ensure that all subordinate commanders are briefed on the FAP within 45 days prior to or following assumption of command. This training will include a discussion of the material contained in the commander education program. (See para 3-2b.)

b. Unit Commanders. Each unit commander will—

(1) Attend spouse and child abuse commander education programs designed for unit commanders.

(2) Schedule time for soldiers to attend troop awareness briefings.

(3) Be familiar with rehabilitative, administrative, and disciplinary procedures relating to spouse and child abuse.

(4) Report suspected spouse and child abuse to the designated RPOC on the installation and provide all relevant information to those investigating the report, including law enforcement agencies and CPS.

(5) Attend CRC case presentations pertaining to soldiers in their command. The commander will only be present for his/her soldier's case presentation, and is not a voting member.

(6) Ensure that soldiers involved in allegations of child and/or spouse abuse, after properly being advised of their Article 31(b), UCMJ rights against self-incrimination, are encouraged to cooperate with FAP personnel to the maximum extent possible from initial report to case closure, to include participation in individual and family interviews or examinations by appropriate social services, medical and law enforcement personnel.

(7) Support and comply with CRC treatment recommendations to the maximum extent possible. Provide nonconcurrence with CRC

treatment recommendations in writing through the chain of command to the MTF commander.

(8) Consider CRC recommendations—

(a) Before requiring soldiers to receive counseling and referral assistance in mandatory counseling programs established under the FAP. (See paras 3-27 and 4-4b on criteria for treatment.)

(b) When taking or recommending disciplinary andadministrative actions in spouse and child abuse cases. However, such actions will not be delayed pending CRC recommendations.

(c) Before recommending deferment or deletion from reassignment of soldiers who themselves or whose family members are receiving professional counseling for spouse or child abuse. (See para 3-32 on the procedures to be followed.)

(d) Before recommending reassignment (or early termination of a duty assignment in a foreign country) when required treatment is unavailable and reassignment is the only available means of providing treatment to the abuser or protecting family members from further abuse. A soldier cannot be reassigned while pending disciplinary action (e.g., court martial, nonjudicial punishment.)

(e) Before initiating personnel actions to separate service members for spouse or child abuse. For officer separations, see AR 635–100;for enlisted separations, see AR 635–200.

(9) Notify the CRC chairperson when orders are issued reassigning soldiers or moving family members who are involved in treatment for spouse or child abuse.

(10) Encourage the participation of civilian family members in treatment programs.

(11) Provide a unit escort when a child must be returned from an overseas command to the states, when appropriate in cases where a CRC representative is unavailable to perform this function.

c. Director, Personnel and Community Activities (DPCA). The DPCA will—

(1) Ensure that programs under his or her direct control have established standing operating procedures (SOPS) for the identification and reporting of spouse and child abuse in accordance with this regulation and existing MOA.

(2) Review and sign all SOPs for programs under his or her direct control.

(3) Support an effective, coordinated installation FAP.

(4) Ensure that the FAP manager has access to the installation commander to conduct briefings in accordance with this regulation.

d. Army Community Service (ACS)officer. The ACS Officer will—

(1) Supervise FAP manager. Monitor and evaluate FAP services provided through ACS.

(2) Oversee funding and resource management.

(3) Ensure that a paid staff person is appointed on orders to serve as the FAP manager.

(4) Ensure coordination with other ACS programs, as appropriate.

(5) Ensure that FAP treatment services are not provided by ACS paid staff or volunteers. Requests for exceptions must be forwarded through the MACOM to USACFSC (CFSC–FSA). MACOM endorsements must include coordination with the major medical command.

e. Installation Family Advocacy Program Manager. As the overall program manager, the FAPM will—

(1) Coordinate the prevention, direct services, administration, evaluation and training efforts of the FAP on the installation to ensure compliance with this regulation.

(2) Serve as the Central POC for all FAP briefing or training requests related to the FAP or to family violence.

(3) Supervise the ACS prevention staff. (See chap 3 for a discussion of prevention services.)

(4) Ensure compliance with DoD quality assurance standards (DoD Manual 6400.1–M).

(5) Provide liaison with civilian and military service providers, and assume lead responsibility for developing and coordinating an installation MOA.

(6) Assess the special FAP needs of military families residing on the installation and in the surrounding communities.

(7) Identify needed resources. Submit budget requirements and manage allocated funds.

(8) Coordinate the management of the installation FAP with other programs serving military families to avoid duplication of effort.

(9) Periodically provide verbal and/or written reports to the chain of command on the status of the FAP, emerging prevention and treatment issues and trends and results of prevention programs conducted. The initial briefing to the installation commander should be conducted within 8 weeks of the commander's assignment.

(10) Consolidate and analyze statistical data on family violence.

(11) Develop a post-wide community education program to-

(a) Inform all personnel about the seriousness of spouse and child abuse, including the causes, effects, and remedies.

(b) Publicize procedures for reporting incidents of spouse and child abuse and available services.

(c) Emphasize the importance of total community involvement in the installation FAP.

(12) Implement ongoing training to ensure each unit commander is briefed on the FAP within 45 days prior to or following assumption of command.

(13) Brief all staff members involved in FAP on the installation (i.e., DPCA, SJA, PM, Chief, USACIDC, MTF Commander, Dental Commander, Alcohol and Drug Control Officer (ADCO), CDS Coordinator, Chaplain, YS Director, and ACS Officer) about the FAP when there is a change in staffing of any of these positions.

(14) Train CDS staff, YS staff, DODDS or DDESS staff, volunteers, and other installation professionals with access to children on how to identify and report suspected child abuse.

(15) Implement a safety education program targeted at children, parents, teachers, and caretakers.

(16) Apply to attend the DoD sponsored FAST Course within a year of appointment as FAPM.

(17) Complete 30 hours of continuing education annually regarding the prevention of spouse and child abuse.

(18) Set up a procedure for liaison and referral with local military and civilian health and human service agencies capable of assisting victims and perpetrators of spouse or child abuse, and maintain a list of existing services, key contact persons, emergency and regular referral procedures, and eligibility requirements.

(19) Serve as a member of the CRC, FAC and the strategy team for out-of-home cases.

(20) Serve as a member of the installation Suicide Risk Management Team(SRMT).

(21) Serve on the CDS Installation Child Care Evaluation Team to participate in quality assurance programs to include completing required forms, e.g., DA Form 4841–R (Child Development Services (CDS)Program/Facility Report). A copy of DA Form 4841–R for reproduction purposes is in the back of AR 608–10.

f. The Medical Treatment Facility (MTF)Commander. The MTF Commander will—

(1) Supervise the multidisciplinary CRC.

(2) Ensure that the Chief of Social Work Service(SWS) or other medical professional with appropriate training and experience, as defined in the DoD quality assurance standards (DoD Manual 6400.1–M), coordinates the MTF services to include spouse or child abuse assessment, intervention and clinical treatment services. On small installations where there are limited resources and no MTF or SWS, the MEDDAC commander or Regional Social Work Service Consultant will designate a senior social work officer with training and experience in accordance with DoD quality assurance standards to be responsible for direct services and clinical counseling.

(3) Develop written protocols to address spouse and child abuse. (See paras 3-19 and 3-23 for examples of particular areas that these protocols should address.)

(4) Ensure that all allegations of spouse and child abuse are reported to the military police or USACIDC as required.

(5) Establish an education program in coordination with the FAP

manager to train members of the CRC in the identification and management of spouse and child abuse.

(6) Ensure that needed medical follow-up care or assistance is provided to the victims and perpetrators of spouse and child abuse.

(7) Ensure that proper medical steps are taken in cases of sudden or unexplained deaths that may be related to abuse.

(8) Provide assistance as required when allegations of abuse involving service members of the U.S. Air Force (USAF), U.S. Navy (USN), U.S. Marine Corps (USMC), or U.S. Coast Guard (USCG) occur on or near an Army installation.

(9) Provide advice and guidance on benefits of the Uniformed Services Health Benefits Program.

(10) Maintain confidentiality of information contained in medical records in accordance with law and regulation.

(11) Ensure that all direct services and supervisory staff in the MTF receive appropriate clinical training through in-service continuing education.

(12) Coordinate all phases of program development with the FAPM to assure that roles and responsibilities for training and counseling services are clearly defined.

(13) Ensure that funding for medical facilities and manpower are adequate and comply with DA policy. Assure that activities can be carried out to meet program objectives of the FAP and that local program needs for required resources are met.

(14) Ensure adequate and appropriate medical staff, clinical, and clerical support to provide crisis intervention, case management, medical or clinical evaluation, diagnostic assessment, counseling, treatment, follow-up, and reporting for all abuse cases. Manpower and funding requirements for this support will be identified and established through the MTF budget process. Assure that personnel providing treatment/intervention services as defined by the DoD standards meet required educational and professional criteria.

(15) Ensure that a standardized intake procedure for spouse and child abuse is established.

(16) Provide local statistics and other pertinent information on the FAP to the FAPM for community and command information programs, to identify trends, and to prepare required reports (e.g., FAP Annual Report).

(17) Periodically report to the installation commander on CRC operations, issues and other pertinent information.

(18) Ensure that the individual against whom an adverse finding is made receives a copy of the published CRC adverse determination review process.

(19) Ensure that the standards of care outlined in Appendix B are consistently applied and incorporated in existing quality improvement and medical protocols.

g. Dental Activity (DENTAC)Commander. The DENTAC Commander will—

(1) Serve, or provide a representative to serve on the CRC as a consultant upon request and as a regular member of the FAC.

(2) Establish an education program in coordination with the FAPM to train dentists and supporting dental staff members in the identification and management of spouse and child abuse.

(3) Develop written protocols to address spouse and child abuse.

(4) Screen dental and medical records in order to identify and record all incidents of injury suggestive of spouse and child abuse.

h. Officer-in-Charge, Personnel Service Company (PSC). The OIC, PSC will—

(1) Give the Chairperson, CRC, access to reassignment rosters to determine if active cases are being reassigned.

(2) Process application for deletion, deferment, and compassionate reassignment based on the soldier's individual situation and the commander's request.

i. Provost Marshal (PM). The PM will—

(1) Serve, or provide a senior representative to serve, as a member of the CRC and FAC.

(2) Conduct preliminary inquiries or investigation involving allegations of spouse or child abuse in accordance with AR 190–30 and AR 195–2 and this regulation.

(3) Coordinate allegations of abuse that occur off the military installation, or when the assistance of civilian law enforcement is required to conclude an investigation with the host-nation law enforcement authorities and collaterally or jointly investigated by the appropriate Army or law enforcement authority.

(4) Notify the RPOC of all reports of spouse and child abuse.

(5) Provide a copy of the Military Police Serious Incident Report (SIR) (AR 190–40) filed in any spouse and child abuse case to the FAPM and, if appropriate, to the CDS coordinator. SIR is always required for child abuse occurring in a DoD sanctioned or operated activity setting.

(6) Ensure crisis intervention training is provided for all military police personnel performing law enforcement duties. Training will be conducted in coordination with the FAPM and will cover the physical and emotional trauma associated with spouse and child abuse, and proper management procedures.

(7) Support the prevention and awareness efforts conducted by the FAPM.

(8) Conduct a check of law enforcement records upon a request from the CRC to determine if alleged spouse and child abusers have had past incidents of behavior requiring military police intervention.

(9) Transport children suspected of abuse to the MTF for medical assessments upon request by the Chairperson, CRC.

j. The local U.S. Army Criminal Investigation Command(USACIDC). The local USACIDC Investigative Unit will—

(1) Notify the RPOC of all reports of child and spouse abuse.

(2) Conduct preliminary inquiries into allegations of assault, aggravated assault, and indecent acts or liberties with a child under the age of sixteen years in accordance with AR 195–2.

(3) Provide a special agent to serve as a member of the CRC and FAC.

*k. Staff Judge Advocate (SJA).*The SJA will—

(1) Serve, or provide a representative to serve, as a member of the CRC and FAC.

(2) Advise commanders and the CRC on applicable laws and regulations affecting current spouse and child abuse cases and other FAP issues.

(3) Advise commanders on disciplinary and administrative actions against soldiers in spouse and child abuse cases and on measures to protect victims from further abuse.

(4) Coordinate with federal, state, local, or foreign authorities, as required, on the criminal prosecution of spouse and child abusers not subject to the UCMJ.

(5) Recommend alternative courses of actions to the commander and the CRC when those actions under consideration are prohibited or otherwise limited by applicable law or regulation.

(6) Participate in the drafting of an installation MOA involving the handling of spouse and child abuse within the command.

(7) Participate in the negotiation and drafting of MOAs with CPS and other civil authorities in the jurisdiction(s) adjoining the Army installation.

(8) Advise the Commander, CRC chairperson, FAPM, and MTF commander on all legal issues regarding the release of information and records, and the extent to which, if at all, the confidentiality of those making reports of spouse or child abuse are protected under applicable laws and regulations.

(9) Advise the Commander, the CRC/FAC, and others as to the extent to which, if at all, State laws mandating the reporting of child abuse apply to those assigned to or residing on the installation.

(10) Advise the Commander and CRC on the legal authority that may be exercised by State and foreign officials over soldiers and family members involved in spouse and child abuse cases residing on and off the installation.

(11) Make legal assistance attorneys available to abused family members and soldiers to advise and counsel them on their legal rights regarding housing and financial support, divorce, legal separation and child custody, and on civil actions and remedies available to them to enforce their legal rights and to protect themselves from further abuse.

(12) Designate one or more persons to serve as victim/witness

liaison through which abuse victims and witnesses may obtain information and assistance in securing available victim/witness services.(See AR 27–10, chap 18 for procedures.)

(13) When feasible and appropriate, appoint legal counsel to represent the abused child in sexual abuse and other cases in which foster care is warranted. Such counsel should coordinate with the case manager to ensure that the interests of the child are fully protected. When local practice permits, this may include interface with local authorities, to include court appearances.

(14) Appoint a judge advocate to serve as a liaison with local civil authorities to ensure that courts conducting civil or criminal proceedings relating to child abuse involving soldiers or their family members are made aware of relevant information, to include the securing of witnesses, documents and other evidence. (See paras 3-33g and 7-9b(3)(d) for the required coordination on treatment referrals to civilian authorities.)

l. Installation Chaplain. The Installation Chaplain will—

(1) Serve, or provide a representative to serve, as a member of the FAC and CRC.

(2) Be responsible for informing the CRC on family compliance with treatment plans when the CRC refers a case to the chaplain program and the chaplain accepts the referral.

(3) Assure that pastoral care is available for soldiers and family members in abuse cases.

(4) Provide programs that promote family wellness, effective parenting, family enrichment, and family spiritual life.

(5) Assure that chaplains providing treatment at Level II as defined by DoD Manual 6400.1–M meet the required education and experience.

m. Installation Public Affairs Officer(PAO). The PAO will—

(1) Conduct media campaigns to increase community awareness of the problems of child or spouse abuse and the availability of resources (e.g., medical, law enforcement, legal and other assistance and counseling).

(2) Coordinate the release of all spouse and child abuse public awareness materials with the FAPM.

(3) Release information to the media. Release of information regarding specific cases of spouse and child abuse that have aroused public concern are particularly sensitive and should be carefully coordinated with the SJA, FAPM, and appropriate law enforcement agencies.

(4) Advise the CRC on public affairs policies and procedures involving child and spouse abuse, including the provisions of AR 360–5 (Public Information), the Privacy Act, the Freedom of Information Act, and the public release of certain investigative reports.

(5) Obtain DA/MACOM public affairs guidance as required for specific situations with potential for adverse publicity for the Department of the Army.

(6) Prepare public affairs assessments and annexes to planning documents.

n. Chief of Dental Services. The Chief of Dental Service will—

(1) Identify and report child abuse as outlined in Chapter 3 of this regulation.

(2) Participate in FAP prevention programs as required.

(3) Educate the members of the CRC on dental identification of abuse and neglect.

(4) Provide consultation to the CRC upon request.

o. Chief of Pediatrics. The Chief of Pediatrics will designate a physician to serve as a member of the CRC and be responsible for providing ongoing, routine medical care to a child when child abuse is suspected or established and will—

(1) Observe children to detect indicators of abuse.

(2) Support and encourage the family in caring for the child.

(3) Conduct medical record evaluations for the CRC upon request.

p. Chief, Department of Psychiatry. The Chief, Department of Psychiatry will—

(1) Provide diagnostic and treatment services on selected cases as discussed and recommended at the CRC meeting.

(2) Serve as a consultant to the CRC upon request.

q. The Community Health Nurse(CHN). The CHN will—

(1) Serve or provide a representative to serve as a member of the FAC.

(2) Provide services directed toward prevention of spouse and child abuse through health education to individuals, families and groups (e.g., new parent support, parenting, child development classes) and coordinate such efforts with the ACS FAP staff.

(3) Assist with identification of high risk families and provide direct services to selected families.

(4) Serve as a nursing consultant to the MTF staff in the identification of suspected abuse cases.

(5) Refer cases to the RPOC when spouse abuse or child abuse and neglect is suspected.

(6) Serve as a consultant to the CRC upon request to provide nursing input into the assessment, intervention, and evaluation process of individual cases.

(7) Receive referrals from CRC for family health counseling and provide this service in the clinic, CHN office, or family home.

r. The Clinical Director, Alcohol and Drug Abuse Prevention and Control Program (ADAPCP). The Clinical Director, ADAPCP will—

(1) Provide evaluation and counseling services to individuals whose alcohol or drug abuse may play a part in spouse or child abuse. (See AR 600–85 for ADAPCP policy.)

(2) At intake, inquire about the existence of spouse and child abuse.

(3) Coordinate with the FAPM to provide training to drug and alcohol counselors in the identification, reporting, family dynamics, and treatment of spouse and child abuse.

(4) Serve as a member of the CRC and FAC.

s. Child Development Services (CDS)Coordinator. The CDS Coordinator will—

(1) Ensure child abuse and neglect identification and reporting criteria training is provided to all child caregivers, providers and volunteers. Training will be conducted in coordination with the FAPM.

(2) Establish internal procedures to ensure that all suspected cases of child abuse are immediately reported to the RPOC.

(3) Screen all child caregivers, (including family child care (FCC)provider applicants for prior involvement in reported incidents of spouse or child abuse under provisions of AR 608–10.

(4) Serve as a member of the FAC.

(5) Participate with the CRC in the treatment plan when an abused child is placed in CDS care after abuse has occurred or when the allegation involves a CDS activity.

(6) Implement a child safety education program in CDS in accordance with this regulation and AR 608–10.

*t. Youth Services (YS) Director.*The YS Director will—

(1) Ensure child abuse identification and reporting criteria training is provided to YS staff and volunteers. Training will be conducted in coordination with the FAPM.

(2) Immediately report all suspected cases of child abuse in accordance with this regulation to the RPOC.

(3) Participate with the CRC in the treatment plan when a case to be discussed has been referred from YS or the treatment plan includes use of YS.

(4) Screen all youth service provider applicants, and volunteers for prior involvement in reported incidents of spouse and child abuse.

(5) Implement a youth safety education program targeted to youth and parents in coordination with the FAPM.

(6) Serve as a member of the FAC.

u. The Principals of DDESS and Department of Defense Schools(DODDS). The principals of DDESS and DODDS will—

(1) Ensure child abuse identification and reporting criteria training is provided to school staff. Training should be conducted in coordination with the FAPM; training will cover physical and behavioral indicators of abuse.

(2) Designate a faculty member to attend CRC meetings when a case to be discussed has been referred from a school or the treatment plan involves school participation.

(3) Immediately report all suspected cases of child abuse in accordance with internal procedures established within each school to the installation RPOC.

(4) Implement a safety education program for children in coordination with the FAPM.

Chapter 2
Organization of the Family Advocacy Program (FAP)

2–1. General

The Army Community Service is the agency responsible for the overall management of the FAP. The medical treatment facility, lawyers, law enforcement personnel, chaplains, and other installation staff, such as the community health nurse, and civilian agencies such as the local child protection services work together to ensure families receive needed services.The FAP manager (FAPM) administers and directs the installation FAP. The FAPM develops community, command and troop education and prevention programs;coordinates civilian and military resources; assesses the special needs of the community; publicizes how to report child and spouse maltreatment and available services; and works with the installation commander to implement programs and services. The FAPM is the installation commander's primary representative and subject matter expert on child and spouse abuse. In this capacity, the FAPM will have direct access to all commanders on the installation. The Case Review Committee, a multidisciplinary team composed of military staff, assesses, evaluates and manages allegations of child and spouse abuse.The installation FAP functional organization chart is at figure 2-1.

2–2. Family Advocacy Program Manager (FAPM)

The FAPM will be appointed by written order by the installation commander.The FAPM will be a social services professional with a master's degree in the behavioral sciences and with a range of administrative, management, prevention, and direct service experience, and will be capable of handling the complex issues associated with spouse and child abuse.

2–3. The Family Advocacy Committee (FAC) and the Case Review Committee(CRC)

a. FAC Composition.

(1) The FAC shall be a multidisciplinary team appointed on orders by the installation commander and shall advise on installation FAP programs and procedures, training, and address administrative details.

(2) The FAC chairperson will be the installation Garrison commander or designee. The FAC may operate as a subcommittee of the installation Human Resources Council. The FAP manager provides logistical support for the FAC.

(3) FAC members may serve for a minimum of one year, subject to reappointment at the end of that period. They should have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse. In addition to the Chairperson, the membership of the FAC will include the following—

(a) FAPM

(b) Chief, SWS/Chairperson CRC

(c) A pediatrician or MTF representative (medical doctor)

(d) Community Health Nurse or representative

(e) Dental Activity Commander or representative

(f) PM

(g) A representative designated by the local USACIDC investigative unit.

(h) SJA or representative

(i) ADAPCP Clinical Director

(j) CDS Coordinator

(k) YS Director

(l) School Liaison Officer

(m) Installation Chaplain or representative

(n) Installation Command Sergeant Major

(o) Child Protective Service representative

(4) The program aspects of FAP will be addressed through the FAC and meetings will be scheduled at least quarterly to—

(a) Provide recommendation for FAP programs and procedures.

(b) Facilitate an integrated community approach.

(c) Recommend new resources and programs needed.

(d) Identify long-range, intermediate, and immediate FAP needs, and initiate action for their implementation to include addressing corrective action plans to comply with DoD quality assurance standards.

(5) The FAPM will report to the FAC on—

(a) Identified trends which may require a command or community response, the establishment of new programs, and plans for implementation.

(b) The results of the command training program, to include the numberof new commanders assigned and number trained.

(c) Special resource requirements.

(d) Results of quality assurance analyses or special Inspector General reports.

(e) Results of prevention efforts to include program schedules, number of attendees.

(6) The Chief, CRC will report to the FAC on—

(a) Number and types of reported and confirmed cases of spouse and child abuse, case transfers,,and closed cases and any trends noted relative to command support of treatment recommendations and commander's attendance at CRC meetings.

(b) Identified trends, special resource or program requirements for treatment.

(c) Identified quality improvement concerns that have community wide impact.

(d) Results of medical quality improvement analyses or special Inspector General reports.

(7) Each member will report on any identified trend related to the FAP which may require a command or community response, the establishment of new programs, status of existing programs, and results of any needs assessments or surveys conducted.

b. Composition of the CRC.

(1) The CRC is a multidisciplinary team supervised by the MTF commander. The CRC's purpose is to coordinate medical, legal, law enforcement, and social service assessment, identification, investigation and treatment functions and command intervention from the initial report of spouse or child abuse to case closure. A treatment team may handle both spouse and child abuse, or separate teams may be organized to handle each type of abuse.

(2) The CRC Chairperson will ordinarily be the Chief, Social Work Service(SWS). When this is not possible, the Chairperson should be a paid professional assigned to the MTF (a military officer or GS-11 or above and meet Level II personnel requirements as defined by the DoD Quality Assurance standards for Treatment services). Any exception to this policy must be submitted through the MACOM by the major medical command for consideration by HQDA (CFSC–FSA). When there is a separate team to address child abuse, this team may be chaired by the Chief of Pediatrics.

(3) Members will be placed on orders by the installation commander for a minimum of one year, subject to reappointment at the end of that period.The CRC is not a public meeting and membership is limited to those members identified in this regulation. Members must have supervisory or functional responsibility for prevention, identification, reporting, investigation, diagnosis, and treatment of spouse and child abuse. The membership of the CRC will include—

(a) The Chairperson (see para 2-3 b(2) above).

(b) A pediatrician. When the CRC is convened to review both child and spouse abuse, an additional medical doctor is not required; however, when the CRC is convened to review only spouse abuse, a Family Practice physician or other medical doctor will be on the Team.

(c) The installation Chaplain or representative.

(d) A representative designated by the local USACIDC investigative unit.

(e) The ADAPCP Clinical Director.

(f) The PM or representative.

(g) The SJA or representative.

(h) The FAPM.

(i) The case manager. (A case manager may vote only on his/her assigned cases.)

(4) Representatives from the following organizations may be requested to act as professional consultants to the CRC and may be invited to attend CRC meetings on an individual case basis. These representatives will not vote on case determinations.

(a) Dental Activity.

(b) Psychiatry/Psychology or Mental Health Activity.

(c) Community Health Nurse.

(d) Child Development Services Coordinator.

(e) YS Director, FCC Coordinators, and school personnel may be invited to attend CRC meetings when the treatment plan includes their participation.

(5) Unit commanders or the civilian supervisory equivalent will be invited to attend CRC meetings when one of their soldiers' cases is scheduled for presentation or review.

(6) CPS representatives may attend CRC meetings when their agency is involved in specific cases.

(7) Neither commanders nor CPS representatives may vote on case determinations.

2–4. Case management functions of the CRC

The CRC through Social Work Service will—

a. Assess reports of spouse and child abuse to identify potential family problems and intervene as necessary to prevent injury to the parties involved.

b. Obtain thorough medical and psychosocial evaluations of children, parents, spouses or any other eligible beneficiaries involved in reported abuse incidents.

c. Complete and forward a DD Form 2486 to the Army Central Registry on all spouse and child abuse reports except as noted below in 2-4(e).

d. Open and close cases of reported abuse and determine, based on the preponderance of information presented, whether the case is substantiated or unsubstantiated.

e. The CRC will complete and forward to the ACR DD Form 2486 on all youthful sex offenders, age 11 years and above, involved in child sexual abuse cases and place a copy of the DD Form 2486 in the victim's case file.The CRC will forward case information on all other youthful offenders, age 10 years and below, to HQDA, (CFSC–FSA), Alexandria, VA 22331–0521, for the purpose of reviewing the case and determining whether identifying information of the offender will be submitted on the DD Form 2486.

f. Ensure the unit commander and MEDDAC Commander(or CDS/YS program coordinator, if the report of abuse involves a CDS/YS sponsored activity, employee, or provider) was notified in each case within 24 hours after the first report of spouse or child abuse was received.

g. Report all allegations of child abuse to the local CPS authorities pursuant to existing MOA, state and federal laws.

h. Determine initial disposition of each specific child abuse allegation discussed at CRC meetings and—

(1) Designate a case manager, if one has not already been designated.

(2) Request the SJA to designate legal counsel to represent an abused child in an appropriate case of sexual abuse or other case in which foster care is warranted.

(3) Conduct a thorough psychosocial assessment, develop a treatment plan and provide follow up services in accordance with approved standards of care, see Appendix B.

(4) Review cases at least quarterly to monitor progress in each case and to reassess the treatment plan.

(5) Determine whether a civilian court or civilian law enforcement agency should intervene.

(6) Determine whether to report or refer a case to CPS or other civilian authorities (e.g., adult protective services) for follow-up action.

(7) Determine whether to recommend the removal of children from their homes.

(8) Provide recommendations for further disposition of the case to the appropriate CPS or other civilian agency, including details of planned follow-up by the Army.

h. Coordinate service delivery in each case of spouse abuse and—

(1) Designate a case manager.

(2) Develop a treatment plan to identify necessary legal, medical, and social services.

(3) Review cases at least quarterly to monitor progress in each case and to reassess the treatment plan.

(4) Maintain case records of all case procedures in accordance with standard record format and guidance provided in Chapter 6.

(5) Initiate and maintain communication with commanders on abuse cases.

i. Refer a family in treatment to the gaining installation or civilian community on reassignment, transfer, expiration of term of service (ETS), or upon retirement of the soldier. (See chap 7 case transfer procedures.)

j. Recommend possible corrective measures to the unit commander of the soldier involved when civilian family members refuse to cooperate with CRC treatment plans.

k. Recommend possible corrective measures in cases where a soldier refuses to cooperate with treatment plans or further rehabilitation is not considered practical.

l. Ensure that the unit commander is advised of the continuing status of cases involving soldiers and their family members. Areas to be covered are expected length of time in treatment, attitude, cooperation, prognosis, and duty limitations. Ways in which the commander may cooperate to facilitate the treatment process should also be discussed.

m. Determine whether or not the medical record is to be coded as a special category record. (See para 6-8 for a description of special category records.)

n. Recommend to the unit commander, when case status warrants, that a request be initiated (by the soldier or the commander) through PERSCOM with a copy forwarded to CFSC–FSA, Alexandria, VA 22331–0521, for a soldier to be deferred or deleted, and stabilized, or that a programmed assignment be changed to a location where adequate resources are available to continue the treatment process.

o. Recommend denial of reenlistment and processing of bar to reenlistment on soldiers whose lack of progress in treatment does not warrant reenlistment.

p. Designate child abuse cases being transferred as"threat-to-life, " "foster care" (other than threat-to-life), or "routine" cases in accordance with the criteria at paragraph 7-3b.

q. Identify those spouse abuse cases being transferred which require special precautions for the continued protection of the victim in accordance with paragraph 7-2.

r. Ensure that each case receives a case determination of substantiated or unsubstantiated. Each case requires a vote by the members on orders and the case determination will be recorded in the CRC minutes. A quorum(two-thirds) of the CRC members on orders must be present to vote on case determinations and a majority of the members must vote to substantiate in order to substantiate a case.

2–5. CRC Administration

a. The CRC should convene, at a minimum, monthly.Written notification of meeting dates shall be provided to all members.

b. Minutes of the meetings must be written in the appropriate AMEDD format and kept on file. (See FN 15-la, AR 25–400–2 for Army policy on maintenance of records). Neither case names nor identification of referral sources will be included in the minutes. Cases will be identified in the minutes by CRC file numbers only. Information on individual cases must include—

(1) The date the commander (or if appropriate, the DoD sanctioned activity director) was initially notified of the abuse report, and the nature of his or her involvement.

(2) Treatment progress.

(3) Additional resources required that were not available.

c. The minutes will be presented to the MTF commander for approval and signature following each CRC meeting. The MTF commander will submit the signed copy of the CRC minutes to the installation commander within 14 work days. At a minimum, the minutes will include the following information—

(1) Administrative: date of the meeting, members present, members absent, others present and issues (i.e., quality improvement, local policy announcements, etc).

(2) Old Cases: Case number, initial presentation due to CRC, determination(substantiated, unsubstantiated), progress and status of treatment, scheduled review date.

(3) New Cases: Case number and type of abuse, date commander notified, CPS notification/involvement, details of incident, determination(substantiated, unsubstantiated), identified problems, treatment plan, commander present, scheduled review date.

d. The CRC will implement a quality improvement program and complete a quality improvement review once a year or as otherwise directed by the MTF commander. Though the CRC chairperson is primarily responsible for the quality assurance review, each member of the CRC and installation staff having responsibility for a particular function will monitor compliance of that function. The purpose is to review the installation program objectively, identify areas that need improvement and develop a plan to improve the program and request needed resources. The self assessment tool developed as part of the DOD quality assurance standards (DOD Manual 6400.1–M) must be used as a supplement to any existing quality improvement measures.

2–6. Chief, Social Work Service (SWS)

The Chief, SWS (or the person appointed as the CRC chairperson when there is no such position at a particular installation) (para 2-3b(2)) will—

a. Serve as the CRC chairperson.

b. Coordinate the MTF treatment program to provide spouse and child abuse assessment, intervention and clinical treatment services, and logistical and administrative support.

c. Work with the FAPM and CRC members to develop an installation MOA that defines the responsibilities of the FAP and CRC.

d. Establish and implement a quality improvement program to monitor and evaluate the MTF responsibilities of the FAP.

e. Ensure a quality improvement review is completed annually or as directed by the MTF commander.

f. Ensure all those individuals to be notified of a spouse or child abuse report are notified in a timely manner and involved from initial investigation to case closure.

g. Ensure a case manager is assigned, a treatment plan is developed (to include a plan of protection) and reviewed quarterly.

h. Submit DD Form 2486 to the Army Central Registry within 10 work days following the CRC determination of case status and review by the Chief, CRC.

i. Ensure proper case transfer procedures are followed, and an up-to-date case record is maintained for each case of abuse.

j. Serve as the primary POC to unit commanders on matters pertaining to treatment.

k. Review the Centralized Personnel Service Center listing on a weekly basis for deletion and deferment information in the Comprehensive Assignment Program (CAP), parts 5 and 8, and for assignment information for the names of soldiers involved in open FAP cases. However, one of the best methods of determining status of soldiers is through the unit commander.

l. Ensure all FAP treatment services staff have access to a current list of existing services, key personnel, and emergency referral procedures.

m. Ensure all direct services and supervisory staff receive FAP annual training.

n. Apply to attend the DoD sponsored FAST course and HQDA sponsored advanced training courses within a year of appointment as CRC chairperson.

o. Submit to the FAPM the names of all CRC team members and SWS staff for nomination to the DoD FAST and HQDA advanced courses.

p. Communicate regularly with the FAPM to assure that roles and responsibilities for training and counseling are clearly defined.

q. Request manpower and funding resources needed for FAP treatment through the medical command FAP manager.

r. Ensure the availability of treatment services in accordance with this regulation and DOD Manual 6400.1–M.

2–7. Funding and Annual Reports

a. All those responsible for the obligation of funds in the FAP will maintain strict accountability for any special Congressional or DA appropriations for FAP to ensure appropriate use. Funding guidance is issued during the fourth quarter of each fiscal year.

b. The FAPM is responsible for completing and forwarding the automated FAP Annual Report and Budget Submit. Guidance is issued during the fourth quarter of each fiscal year.

2–8. Staffing

a. Commanders will provide professionally trained personnel of appropriate rank or grade based on the size and needs of the installation to ensure that quality FAP services are available. At a minimum, there will be a FAPM to operate and manage the program on each Army installation. For general staffing procedures, see DA Pam 570–551, Staffing Guide for U.S.Garrisons, and AR 570–5, Manpower Staffing Standards Systems (MS3).

b. DOD Manual 6400.1–M sets minimum qualification for FAP professional practitioners engaged in providing Level One and Level Two Intervention and Treatment Services. To ensure standard program quality and service delivery, installations and MTFs will comply with published guidance concerning staffing of the FAP.

c. Case managers will be professionally trained individuals assigned to SWS. Any exception must be submitted to the medical MACOM for consideration.

2–9. Training

a. All FAP personnel will receive training to enable them to execute their responsibilities.

b. MACOM and installation FAP staff will—

(1) Apply to attend the DoD sponsored FAST Course within the first year of assignment.

(2) Apply to attend the HQDA sponsored Family Advocacy Staff Training Advanced courses.

(3) Attend FAP workshops sponsored by HQDA(CFSC–FSA) and OTSG.

(4) Assure a regular program of in-service technical training is provided for staff assigned to work with the FAP.

c. The FAPM and appropriate MTF staff will participate in continuing education regarding spouse and child abuse at least once every twelve months.

d. All installation staff officers and tenant organizations (e.g., Chaplains, SJA, PM, USACIDC, MTF emergency room, nursing, SWS staff) involved in cases of spouse and child abuse will coordinate with the FAPM to provide training at least annually to all their personnel regarding proper procedures in identifying and responding to reports of spouse and child abuse.

2–10. A cooperative approach

Regardless of the type of Federal legislative jurisdiction that exists on an Army installation, Army authorities on the installation should establish a cooperative relationship with local communities in identifying, reporting, and investigating child abuse cases; in protecting abused children from further abuse in both emergency and non-emergency situations; and in providing services and treatment to families in which child abuse has occurred. Whenever possible, this

cooperative relationship should exist in addressing problems associated with spouse abuse as well.

2–11. Memoranda of agreement (MOA)

a. The use of memoranda of agreement in the United States between Army installations and adjoining local communities in addressing problems of spouse and child abuse within military families is required. In cases where civilian state agencies refuse to enter such an agreement, the installation FAPM must notify USACFSC (ATTN: CFSC–FSA), ALEX, VA 22331–0521, through their MACOM. Information on the jurisdictional factors and Federal-State relationships that should be considered in drafting these MOAs is at Appendix D. A suggested format for a MOA is at Appendix C and para 2-14.

b. MOAs with adjoining local communities are not necessary with regard to Army installations located outside the United States. In foreign countries, any agreement between commanders and host nation authorities would be regulated by the Case Act (1 U.S.C. section 112b). AR 550–51 addresses the authority and responsibility for negotiating, concluding, forwarding, and depositing international agreements.

c. All MOAs and other agreements should be reviewed by the supporting SJA or equivalent legal advisor.

2–12. Key people and agencies

There are a number of key people and agencies on the installation and in the civilian community that should be involved in any cooperative approach to handling child abuse cases. All these need not sign a MOA between the Army installation and civilian community, but their roles should be addressed somewhere in the MOA when one is executed.

a. Military

(1) Installation or Army Community Commander.
(2) DPCA.
(3) ACS officer.
(4) MTF Commander.
(5) Chief, SWS.
(6) FAPM.
(7) CRC.
(8) RPOC.
(9) PM.
(10) USACIDC.
(11) SJA.
(12) Chaplain.
(13) FAC.

b. Civilian

(1) Chief, CPS.
(2) County or District Attorney.
(3) Presiding Judge of Family or Juvenile Court.
(4) Other agencies as appropriate.

2–13. Contents of MOA with local authorities

Where there is willingness between the installation and local community to execute a formal MOA on the handling of child abuse cases, the MOA should address the following—

a. The legal authority of the installation commander over military discipline and law and order on the installation.

b. The legal basis for the MOA and the exercise of jurisdiction by local authorities on the installation.

c. A description of the legal authority exercised by key people and agencies on and off the installation that are governed by the MOA.

d. The extent to which reports of child abuse and case information will be shared by the parties to the MOA, with regard to both on-and off-post incidents of child abuse.

e. The agencies that have primary responsibility for assessing andinvestigating child abuse cases, and the coordination required.

f. The agencies that are responsible for responding in emergency and non-emergency situations and the actions to be taken to protect children in such cases from further abuse, including the procedures to be followed in obtaining court authorization to remove abused children from their homes, to place them in foster care, and to take other actions necessary to protect them from further abuse (e.g., child protective orders).

g. The agencies primarily responsible for providing services and treatment to families in which child abuse has occurred.

h. MOAs may also be established with local shelters offering services to battered women, and other agencies to facilitate and define services to be offered.

2–14. Installation MOAs

The FAP manager shall coordinate MOAs between military and civilian agencies involved in the FAP to facilitate collaboration. Each MOA will delineate local policies, responsibilities, and functions according to this regulation.At a minimum, the following areas should be addressed in the MOA—

a. Prevention, Education, and Awareness.
b. Identification.
c. Reporting and Notification Procedures.
d. Crisis Intervention.
e. Intake Procedures.
f. Assessment/Investigation.
g. Case Management.
h. Treatment and Support Services.
i. Records Management.
j. Out-of-Home Assessment/Investigation Procedures.
k. Quality Assurance.
l. Program Evaluation.
m. Notification and Involvement of the Commander.
n. Liaison with Local Courts and Agencies.
o. Threat-to-Life Transfers.
p. Training.
q. Schematic Flow Chart for Case Handling.
r. Policy for Responding to Media Inquiries.

2–15. Periodic review of MOAs

a. The FAPM will identify installation procedures that do not comply with this regulation and bring them to the attention of the installation commander. Corrective actions with milestones will be written into the MOA.

b. The FAPM will conduct an annual review of all existing MOAs on the installation and with local authorities for compliance with this regulation, and will make recommendations to the installation commander to correct deficiencies.

c. The SJA will review new or modified MOA for legal sufficiency and statutory compliance prior to implementation.

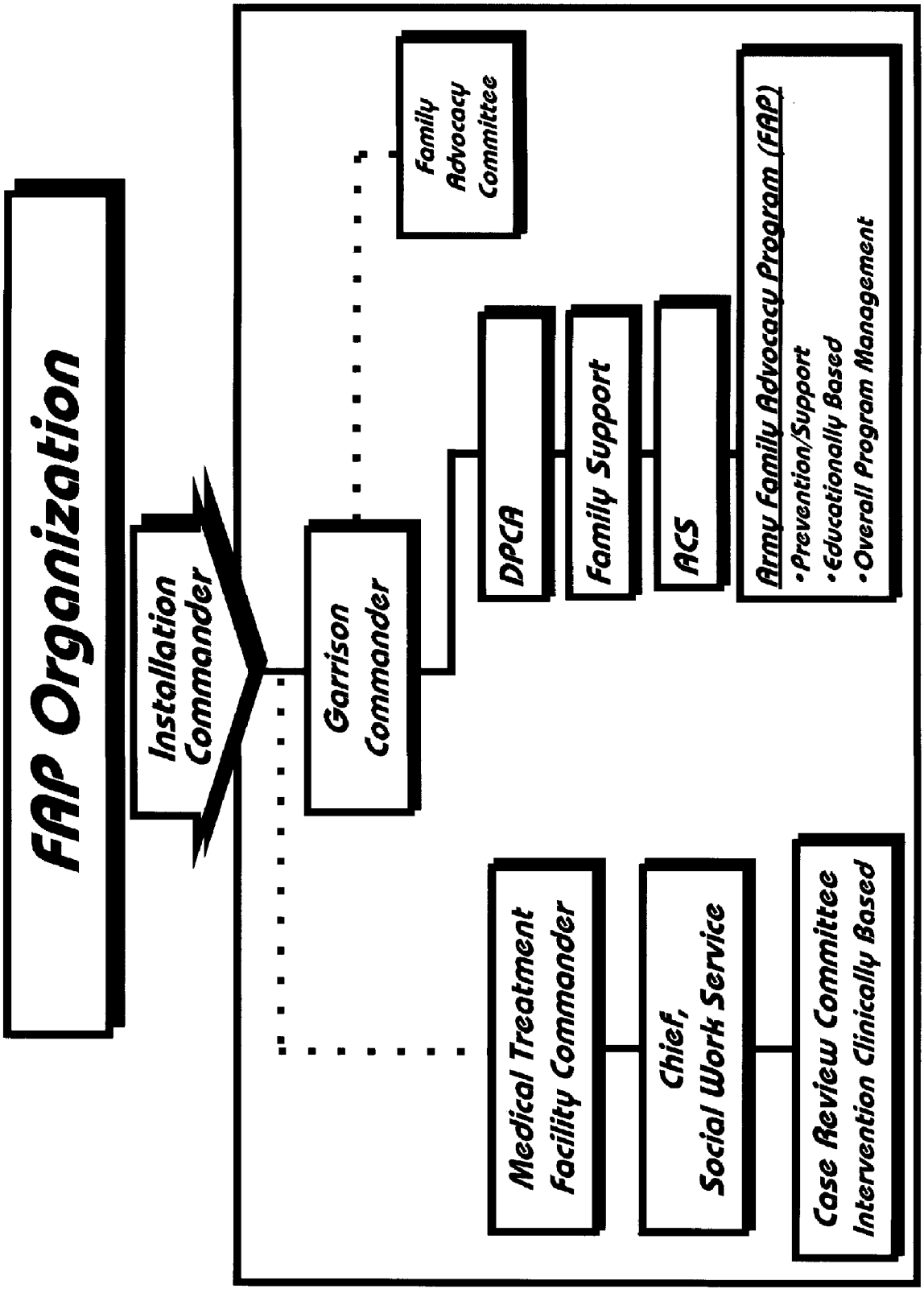

Figure 2-1. Family Advocacy Program Organization

Chapter 3
Response to Spouse and Child Abuse

Section I
Prevention of Spouse and Child Abuse

3–1. General

a. Army installations will provide services designed to prevent spouse and child abuse by improving family functioning, easing the kinds of stress that can aggravate or trigger patterns of abusive behavior, and creating a community that is supportive of families. The prevention program is designed to create community and command awareness of abuse, provide information of existing services, and provide specific educational programs. An important part of prevention is that it provides services to eligible families on the installation and in the surrounding civilian communities who have special needs and stresses (e.g., young and inexperienced families, families with closely spaced children, single parent families, lower income families, families with parents who are soon to deploy, families with exceptional members). Child abuse prevention programs will address abuse in both family and out-of-home settings (e.g., quarters and facility-based CDS programs).

b. The FAP recognizes that—

(1) Prevention is a continuum that includes awareness, education, and intervention in high risk situations.

(2) Prevention is a community responsibility—no single individual, agency, organization or discipline alone can implement an effective and comprehensive program

(3) A multidisciplinary team providing interdisciplinary support coordinated through family advocacy is the best way to build strong and resourceful individuals, couples, and families and to ensure safety for all members of the community.

c. A flexible blend of prevention activities and programs (primary, secondary, and tertiary) offered in a variety of formats is the most effective way to address the prevention and reduction of family violence. Primary prevention is community based, promotes wellness for everyone, and commits resources to enhance healthy individual, couple and family functioning. Everyone can contribute to, and benefit from, primary prevention activities. Primary prevention creates a climate of awareness that encourages voluntary participation. Stress management classes, new parent support programs, couples communication groups, parent-child groups, marital enrichment programs, home visiting programs, child care opportunities, parent education classes, and family wellness programs are just a few of the delivery strategies for implementing effective primary prevention.

d. Secondary prevention refers to those activities and services offered on a voluntary basis to individuals, couples or families considered to be "at risk" because of their current life situation. Secondary prevention programs and services address early symptoms of stress and crisis before they escalate into violent behavior, establish and reinforce safety limits, defuse crisis and focus on changing precipitating behaviors and conditions before family violence starts.Support groups for teenage parents or single parents, programs for families with exceptional family members, outreach programs for isolated families, more intensive home visitor or parent aide programs (depending on the needs of the family), anger control or alternative discipline classes or financial counseling are all examples of secondary prevention strategies.

e. ACS FAP prevention staff are concerned with primary and secondary prevention programs. MTF staff are responsible for tertiary prevention which within this context means assessment, intervention, and treatment services after an allegation has been made. MTF staff may also offer secondary prevention support services within the context of general social work services to families identified as "at risk"(e.g., SWS staff assigned to pediatric or obstetrics/gynecology clinics may identify "at risk" soldiers and families). Services provided by SWS to "at risk" families must be properly documented according to published medical protocols. A DD Form 2486 is not required to be completed on "at risk" cases. The necessary support services may be acquired with family advocacy resources.

3–2. Required prevention programs

All installation FAPMs are responsible for coordinating the required prevention programs discussed below; however, all FAP services do not need to be ACS/FAP initiated programs. FAPMs should review available services to avoid duplication whenever possible. The services may be provided by installation staff, contracts, other military agencies, or by a civilian agency when their services are available and accessible. A MOA or some other official written documentation describing responsibilities must be on file in ACS to ensure service is provided to soldiers and their families.Prevention programs (such as family life education, parent education, new parent support and parent aide programs) should be conducted based on the results of community wide needs assessments.

a. Community Education Program. This informs the military community of the extent and nature of spouse and child abuse, and focuses awareness of family violence, how to report it, and available services. Community education involves making FAP services known, accessible, and attractive to those in the military community who can best use the services to improve their family functioning. The purpose is to promote community support and encourage early referral. Minimum requirements for community education are monthly media contacts (e.g., bulletins, newspapers, radio, television), a monthly presentation to groups (e.g., spouses' groups, parent-teacher associations (PTA), church groups), participation in all appropriate special military community and unit events(e.g., health fairs, organization days) and participation in special theme events (e.g., Child Abuse Prevention Month, Month of the Military Child, and Domestic Violence Month).

b. Commander Education Program. This covers education regarding the FAP to ensure that commanders at all levels are aware of—

(1) The nature of spouse and child abuse and how to prevent it.

(2) FAP policies and procedures.

(3) Available FAP services.

(4) Command responsibilities for identification, reporting, and coordination with the CRC.

(5) Information on FAP prevention services.

(6) Mandatory briefing requirements for unit commanders within 45 days after appointment to a command position.

c. Troop Education Program. This consists of annual education for all soldiers on the family dynamics of spouse and child abuse, availability of prevention and treatment services, and the Army's policies regarding family violence.

d. Education for Professionals Program. This program provides semi-annual education for professionals and para-professionals who work with children (e.g., those working in CDS, YS, and schools) to ensure that they are aware of the seriousness of child abuse, the causes and effects of child abuse, the identification of child abuse, and the reporting responsibilities of child abuse.

e. Parent Education and Support. Parent education and support programs develop skills in physical care, protection, supervision and nurturing appropriate to a child's age and stage of development; build or enhance strengths that the individual brings to the parenting role; enhance parent-child attachment and provide role models and assistance in the form of home visitors and/or parent aides. Skills development and information-sharing opportunities that enhance the parents' ability to interact more effectively with their children and to create and maintain a safe home environment in which self-esteem and learning are encouraged.

(1) Parent Education Program. This program involves education that is designed to enhance parenting and child management skills (e.g., Parent Effectiveness Training (PET), Systematic Training for Effective Parenting (STEP), Active Parenting). Parent education and support groups may be combined to provide a forum for parents to exchange ideas, information, and resources, and to practice new behaviors. The program may also reinforce or teach parents basic skills in physical care, protection, supervision, and psychological nurturing appropriate to a child's age and stage of development.

Programs target groups such as newly married individuals, expectant parents and parents of teenagers.

(2) New Parent Support Program. This program reaches out to new or young families to enhance parent and infant attachment, to increase knowledge of child development and to provide connections to the support services that allow the parents to become nurturing and capable caregivers. The program includes health counseling for expectant and new parents to enhance parent and infant bonding.

(3) Home Visitor/Parent Aide Program. Home visiting programs vary in design and implementation but share a common rationale of assisting parents improve coping skills and accept responsibility for defining their own goals and making their own decisions.As a primary prevention model, voluntary home visitors meet with new parents to help them get off to a good start and serve as a friend/role model and information and referral resource. For families already involved in family violence situations, a more intensive level of home visiting by parent aides may be required by the CRC as part of the treatment plan. Nurses and other home health staff, professional mental health staff, students, and a wide range of volunteers have all been used successfully as home visitors, parent partners, mentoring moms and parent aides.

f. Safety Education Programs. There are two target groups for safety education. The first target group is composed of parents, teachers, caregivers, and all concerned adults in the community. This audience needs information about how to protect children and how to listen to and talk with children on child sexual abuse prevention. Children need to have programs and activities geared to their ability to understand and act on safety and exploitation issues including child sexual abuse. Education programs should help children develop skills to protect themselves against sexual abuse and may include other community efforts such as finger printing and neighborhood safehouse programs. These programs will be made available to children enrolled in CDS activities (6 years and above), YS, DODDS and DDESS.

g. Spouse abuse prevention programs.Strengthening and stabilizing intimate relationships is one approach to preventing marital distress and spouse abuse. The goals of spouse abuse prevention programs are to enhance and sustain communication, decision-making and conflict resolution skills and to clarify perceptions within the relationship. Prevention strategies may include educational programs and interactive workshops on couples communication, conflict resolution, assertive training, stress management and marital enrichment classes and programs for children who witness violence.

h. Family Life Education. This is education focusing on enrichment programs that provide knowledge, social relationship skills, and support throughout the family life cycle. The goal is to improve life management and family coping skills, enhance self-esteem, and improve communication skills and marital relationships.

Section II
Identification of Spouse and Child Abuse Incidents

3–3. General

The indicators of abuse are not concrete evidence of abuse. The determination of abuse requires an analysis of the nature of the injury, location on the body, severity of the injury, number of indicators, relationship between the indicators, the description of the injury, and an analysis of the physical findings considered in light of the total assessment and investigation.

3–4. Indicators of spouse abuse

a. The victims of physical assault often suffer multiple injuries. Spouse abuse may be suspected when an explanation of an accident is inconsistent with the injury sustained or when there are multiple injuries on the face, neck, chest, breasts, or abdomen with no reasonable explanation. Research has shown that women are at greater risk of spouse abuse during pregnancy. Presence of these injuries during pregnancy is especially suspicious.

b. Dental personnel are often aware of unexplained lacerations in the mouth and tongue, facial abrasions, or broken teeth, jaw, or cheek bones. In suspicious cases, appropriate medical and dental protocols require that physicians, dentists, social workers, and nurses begin to actively check for the possibility of abuse.

3–5. Indicators of child abuse

a. The possibility of child abuse exists whenever an injury occurs without adequate explanation for the degree of injury sustained. The possibility is greater when the explanation of the accident is not logical, or when there are changes or conflicts in the information provided. In treating children, MTF personnel will look for multiple fractures, unexplained coma, unexplained apnea, repeated toxic ingestions, pathognomonic injuries such as belt marks, wire loop marks, and cigarette burns. Any hospital or medical facility determination that a child is dead on arrival should trigger an especially tactful, skilled inquiry into the possible existence of child abuse. While severe bruises, multiple fractures, subdural hematoma, and severe burns may arouse suspicion of abuse, the physician should not limit identification to those severe forms of physical abuse, but should aim to identify less severe abuse as well.

b. Any injury could be an indicator of child abuse. The treating physician should consider the following—

(1) Does the history explain the physical findings?

(2) Is the child developmentally capable of injuring himself or herself as the history describes or is reported?

(3) Could the injury have been prevented by better supervision?

c. Dental services may detect possible child abuse when facial abrasions, a broken jaw, cheek bones or teeth, lacerations in the mouth or tongue, or other indicators are present. Such indicators may include evidence of recent trauma to the face, neck, mouth, or jaw.Radiographs of the teeth and jaw may reveal evidence of healed or healing fractures of bones and teeth. Soft tissue injuries, such as a lacerated frenum accompanied by a bloody nose may be indicative of abuse. Condylar fractures may be the result of trauma to the jaws and could result in abnormal occlusal patterns following healing of the fracture.

d. Child sexual abuse may exist when a child has any genital trauma, vaginal bleeding, or rectal trauma, or when a child expresses a history of sexual activity or a knowledge of explicit sexual activity beyond that which would be expected for that child's stage of development. All cases of venereal disease, especially in preteens, should be evaluated as possible sexual abuse.

e. Neglect tends to be chronic in nature and involves inattention to the child's minimal needs for nurturing, food, clothing, shelter, medical care, dental care, safety or education. The possibility of neglect should be considered in cases where there has been an unexplained failure to thrive or where there has been an advanced untreated disease. Except as otherwise defined by applicable law, a finding of neglect is usually appropriate in any situation where a child under the age of 9 is left unattended (or left attended by a child under the age of 12). A finding of neglect is also appropriate when a child, regardless of age, is left unattended under circumstances involving potential or actual risk to the child's health or safety. Dental neglect is defined as the failure by a parent to seek treatment for visually untreated dental caries, oral infections or pain, or failure by the parent to follow through with treatment once informed that any of the above conditions exist.

Section III
Reporting of Spouse and Child Abuse Incidents

3–6. Report point of contact (RPOC)

a. Each installation will establish a telephone reporting system for handling all reports of spouse and child abuse to include abuse which occurs in a DoD sanctioned or operated activity for children (e.g., CDS, YS). Separate systems may be established for reporting spouse and child abuse. The system should be tailored to each installation's size, location, and other unique factors (e.g., the presence of a military police station or "MP desk," the existence of MOAs with CPS, the presence of a spouse abuse shelter, the availability of an MTF Emergency Room). In most instances, the central

location for receiving reports of abuse should be the MTF emergency room or MP desk, when available.Procedures for documentation of reports, initiation of prompt investigation, and notification of unit commander will be established by MOAs and medical protocols, as appropriate. As a matter of Army policy, the reporting procedures within these documents will comply with applicable State laws mandating the report of child abuse to the extent permitted by Federal laws, executive orders, and regulations. (See M.R.E. 502 and 503, Manual for Court Martial, United States, 1984, on privileged communications.)

b. At a minimum, the report system established will require a single RPOC for all reports of abuse. The installation commander will designate the RPOC. The RPOC will be accessible to the military community, both on and off the installation, on a twenty-four hour a day basis.

c. The local telephone number for reporting abuse will be given ongoing publicity.

d. Despite local efforts to publicize a central point of contact to receive reports of abuse, several activities on the installation can expect to receive initial reports. The person receiving the report should record the information with as much detail as the reporter is able or willing to provide. The person receiving the report should immediately inform the RPOC, who in turn will, notify the CRC chairperson of every report received. (See para 3-15 on the requirement to notify the military police.) Any investigation that follows will be conducted according to applicable laws and regulations, and existing MOAs.

3–7. Army reporting requirement in abuse cases

a. Every soldier, employee, and member of the military community should be encouraged to report information about known or suspected cases of spouse and child abuse to the RPOC or the appropriate military law enforcement agency as soon as the information is received. (See Appendix E regarding privileged communications.)

b. All installation law enforcement personnel, physicians, nurses, social workers, school personnel, CDS and YS personnel, psychologists and other medical personnel will report information about known and suspected cases of child and spouse abuse to the RPOC as soon as the information is received.

c. Commanders should report allegations of abuse involving their soldiers to the RPOC.

3–8. Promise of confidentiality

a. A confidential source is a person or organization that has furnished information to the Army under an express promise that his, her, or its identity would be withheld. A source that provides information to the Army without an express promise of confidentiality is not a confidential source. The content of a report made by a confidential source may be disclosed only in accordance with applicable laws and regulations. However, not all criminal investigations or trials result in the identity of confidential sources being disclosed to alleged abusers. A promise of confidentiality does not necessarily confer any immunity from disciplinary action. Requests for immunity must be referred to the SJA for processing under provisions of AR 27–10, paragraph 2-4.Only an appropriate General Court-Martial Convening Authority may grant immunity to a soldier. The SJA must forward requests for immunity on behalf of a civilian to the Department of Justice for action.

b. In order to encourage soldiers, family members, and others living and working in the military community to report all incidents of spouse and child abuse, Army personnel, volunteers working in the FAP and those performing law enforcement duties may accept and promise to record anonymous reports. A promise of confidentiality ordinarily will not be given unless it is necessary to encourage the person to make a report of spouse or child abuse. All express promises of confidentiality must be reported to the C, CRC for documentation in the file. A promise of confidentiality may be appropriate in cases where the person making the report of abuse is a neighbor or relative of the abused spouse or child, or other interested party. A promise of confidentiality ordinarily is inappropriate when the person making the report has an independent duty, by virtue of his or her status, employment or duty position, to discover, report, investigate, or treat abuse (e.g., physicians, nurses, social workers, law enforcement personnel, school personnel, CDS, YS personnel, and clinical psychologists). Any person making a promise of confidentiality must explain the limits of confidentiality as set out in subparagraph (a) above.

c. CRC records containing written statements or summarized written reports of oral statements taken from persons whose identity the Army has expressly promised to withhold will be marked-"Express Promise of Confidentiality Given," together with the name of the person making the promise and the date upon which the promise was given and the identity of the authorizing individual.

d. The identity of a confidential source, together with his or her statement, may be released to officers and employees of DOD, including those performing law enforcement duties, who have a need for this information in performing their duties or as otherwise authorized by law(e.g. to the FBI, DOJ, state and local authorities). The release of confidential information to third parties (e.g., private citizens, DOD officials acting in an individual capacity) or those to whom the information pertains (e.g., victims of abuse, abusers, or attorneys requesting such information in their behalf) will be in accordance with law and regulation.(See M.R.E. 507, MCM, AR 25–55, and AR 340–21 for restrictions and procedures regarding the disclosure of information pertaining to the identities of informants and confidential sources.)

e. The SJA will be consulted for legal advice on the extent to which the identity of those making reports of spouse or child abuse may be protected under applicable laws and regulations.

3–9. Reports to commanders

The Chairperson, CRC (or other persons designated by an installation MOA) will notify the appropriate commander within 24 hours after receiving any report of spouse or child abuse pertaining to the family of one of his or her soldiers. Date of notification will be recorded in the CRC file. The initial report will provide the commander with all available and relevant information, including, but not limited to the type of abuse, identified abuser (if a determination has been made), the case manager, and the date and time of the next CRC meeting at which the case will be reviewed.The initial report to the commander normally should be regarded as a report of suspected abuse. The primary purpose of this initial report is to share information during the assessment. Subsequent reports are the responsibility of the designated case manager. These reports should include the expected length of time in treatment, attitude of the abuser, his or her degree of cooperation, programs of treatment, and duty limitations. Ways in which the commander may facilitate the treatment process will also be suggested. (See para 3-29 for command communication procedures.)

3–10. Reports from States

a. The FAPM will request the appropriate officials of the state or states in which the military installation is located, and in which soldiers and their families reside, to provide full case information on all known and suspected instances of child abuse involving soldiers and theirfamily members.

b. All instances in which any state refuses to provide such reports will be reported through MACOMs to HQDA(CFSC–FSA), Alexandria, VA 22331–0521.

Section IV
Evaluating Allegations of Spouse and Child Abuse

3–11. General

a. The evaluation of allegations of child and spouse abuse is twofold. The primary purposes are to gather investigative facts and conduct psychosocial and family assessments necessary to protect the victim of abuse and provide necessary support services. Information is gathered by interviewing available witnesses, discovering the

identity of other witnesses and interviewing them, and collecting physical evidence.Physical evidence may include photographs of injuries inflicted in an assault, medical specimens taken from the victim of an alleged sexual assault, and weapons or other items used as weapons during the course of an alleged assault.

b. Social workers, medical personnel, and law enforcement personnel share a common interest in ensuring that all reports of spouse and child abuse are promptly and fully investigated and assessed. A prompt and full assessment and investigation is particularly important in a child abuse case because such cases often involve victims who are too young or too frightened to explain what happened to them, or to report it. In child abuse cases, the prompt gathering of physical evidence, before it disappears or is destroyed, is essential.

c. Both social workers and law enforcement personnel have a responsibility to protect the victims of abuse from further physical and emotional harm. Emotional harm or trauma can be unintentionally caused by unnecessary and repeated questioning of victims by the various agencies involved in the assessment or investigation, as well as by the approach taken or attitude displayed by those doing the questioning. All personnel must be sensitive to the emotional needs of victims when conducting such questioning.

3–12. Objectives of Assessment/Investigation

The objectives of any assessment or investigation of a reported spouse or child abuse case are—

a. To gather all of the evidence by every lawful means available, including, when appropriate, the use of—

(1) Search authorizations (Military Rule of Evidence (MRE) 315, Manual for Courts-Martial (MCM) 1984 or warrants

(2) Authorizations to apprehend (Rule for Courts-Martial(R.C.M. 302 MCM 1984) or warrants to arrest

(3) Photographs

(4) Scientific examinations and findings

(5) Medical examinations and findings

(6) Psychosocial and family assessments by social workers

b. To gather the evidence as quickly as possible to prevent its destruction.

c. To gather the evidence in a lawful manner by—

(1) Properly advising soldiers suspected ofcriminal acts of abuse of their rights under Article 31, UCMJ, before questioning them about suspected or known instances of abuse.

(2) Ensuring appropriate command and law enforcement involvement in any medical or social work inquiry of a child or spouse abuse case whenever there is probable cause to believe that a criminal act of abuse has occurred (e.g., assault, battery, indecent assault, indecent exposure).

d. To protect the victim of abuse from—

(1) Further physical harm by making an immediate apprehension or by requesting the appropriate commander take the necessary measures to restrain the suspected abuser or to isolate the victim from the abuser (e.g., restriction, bar from the military installation, medical protective custody).

(2) Emotional trauma by avoiding unnecessary and repeated questioning of the victim.

e. To make accurate and timely findings of fact that are supported by all the available evidence.

3–13. Cooperative effort

In order to accomplish the objectives set forth in paragraph 3-12, this regulation mandates a cooperative effort by law enforcement, medical, and social work personnel in responding to all spouse and child abuse reports, to include a sharing of information and records insofar as permitted by law and regulation. (See para 6-2b on the Army policy in sharing record information.)

3–14. Action on receiving initial reports

a. Assessment or investigation of a report of spouse or child abuse should never be undertaken as an individual effort by the source of the report. Although a family member, family friend, neighbor, teacher, or innocent bystander may ask questions of the victim or other person making the initial report of abuse, such inquiries should be limited to verifying that the allegation has merit. The RPOC or appropriate law enforcement agency should be notified immediately of any suspected or known abuse.

b. Military law enforcement personnel will immediately notify the RPOC when a report of spouse or child abuse is initially received. Although a law enforcement investigation will not be delayed to await participation by social workers, interviews of child victims should ordinarily be conducted with social workers present in order to avoid multiple interviews.

c. When doctors, nurses, social workers, or others involved with providing treatment in the FAP initially receive a report of spouse or child abuse, the person receiving the report will make an immediate report to the RPOC.

d. When CPS or other civilian authorities from local jurisdictions adjoining the installation receive a report of on-post or off-post spouse or child abuse, the RPOC will be notified in accordance with the MOA with local jurisdictions.

e. In appropriate cases, the SJA may designate legal counsel to represent an abused child in order to fully protect the interests of the abused child in sexual abuse cases and other cases in which foster care is warranted. Legal counsel in these cases will be provided as soon as possible. Counsel will work closely with the case manager to ensure that the child is protected throughout the investigation and subsequent proceedings.

3–15. Mandatory notification of military police

a. If the RPOC is other than the military police, the RPOC will notify the military police of every report of child abuse involving a possible criminal offense as soon as the report is received.

(1) Child abuse in the form of an assault, or an assault and battery, is not a criminal offense under the UCMJ if it can be justified on the basis of administering reasonable parental discipline to a child. Any act of punishment exceeding reasonable parental discipline is unlawful and should be reported to the military police. Where applicable, state or foreign criminal law may provide a different standard on this issue.

(2) All child abuse involving crimes such as assault, assault and battery, carnal knowledge, indecent assault, rape, sodomy, indecent exposure, indecent acts or liberties with a child, and other forms of sexual exploitation will be reported to the military police or USACIDC.

(3) All child neglect involving violations of applicable child protection laws (e.g., school attendance laws) or wanton disregard or malicious intent on the part of the parent will be reported to the military police.

(4) The military police will be immediately notified of any report of child abuse alleged to have occurred in a DoD sanctioned or operated activity, or involving any child care employee or volunteer, including babysitters who are providing care on the installation.

b. All allegations of spouse abuse will be promptly reported to the military police, including incidents which require medical treatment, hospitalization or out-patient treatment in a MTF emergency room.

c. All agencies will immediately notify the military police whenever assistance is required to protect any victim from further abuse or harm.

3–16. Action by the RPOC

When a report of abuse is received, the RPOC will immediately—

a. Notify the military police (if not previously notified);

b. Notify the CRC (so a timely report can be made to the appropriate commander and a case manager assigned).

c. Notify the CDS or YS coordinator, as appropriate, when a report involves child abuse alleged to have occurred in aCDS or YS quarters- or facility-based operation, or involves a CDS or YS child care employee or volunteer.

3–17. Interviewing the reporter of abuse

a. The person reporting the abuse should be fully questioned before others are questioned in the case.

(1) When the person making the report of abuse is a soldier suspected of a criminal offense under the UCMJ, such questioning will be preceded by an advisement of rights under Article 31, UCMJ (para 3-21).

(2) When the person making the report of abuse is a child victim of abuse, such interview should be conducted with the participation of law enforcement and social work personnel.

(3) When the person making the report is a civilian suspected of a criminal offense, such questioning will be preceded by an advisement of rights against self incrimination only when the questioning constitutes custodial police interrogation.

b. Any person receiving an initial report of spouse or child abuse from an anonymous telephone caller should obtain as much information as possible about the abuse, including dates, times, places, and persons involved, as well as the basis of knowledge that the caller has for concluding that abuse was actually inflicted (e.g., personal observation, personal conversation with the victim or a family member). Anonymous callers should be encouraged to make their identity known. When authorized by competent authority to do so, Army personnel and volunteers working in the FAP and those performing law enforcement duties may promise to maintain the identity of the person making the report in confidence. (See para 3-8 on promises of confidentiality.)

3–18. Interviewing the victim of abuse

a. Spouse abuse. Victims of spouse abuse should be protected from further trauma caused by unnecessary or repeated questioning by the various agencies involved. This regulation mandates, whenever possible, coordinated joint interviews by law enforcement, medical and social work personnel. Victims should be interviewed separately, outside the presence of the offender. All initial allegations of spouse abuse will be reported to the RPOC, regardless of by whom they are received. The various installation agencies should report pertinent information to the SWS case manager for purposes of completing the psychosocial/family assessment and presentation of the case to the CRC.

b. Child abuse

(1) This regulation mandates a coordinated effort by law enforcement, medical, social work personnel in interviewing victims of child abuse. An MOA with the local jurisdictions should, whenever possible, describe the procedures that will be followed to prevent unnecessary and repeated questioning of child victims by the various agencies involved in the investigation.

(2) When victims of child abuse are able to provide information about the abuse incident, they should be interviewed before the alleged abuser is interviewed. Where one or both of the parents are suspected of inflicting the abuse or in concealing information about the abuse, the child victim should be interviewed outside the presence of the parent(s). Unless otherwise required by applicable law, parental consent is not required to interview children suspected of being abused by one or both of their parents. If parental consent is not obtained, the interview of a child victim will only be conducted with the participation or consent of the law enforcement or CPS agency having jurisdiction in the case.

(3) The place of the interview will depend on the circumstances of the case. Interviews will be conducted in a private setting with as little attention called to the event as possible. If the child's statement constitutes the initial report of abuse, any follow-up interview should involve all agencies that will be participating in the investigation of the case. Information should be obtained not only from interviewing the child victim, but, if appropriate, from a medical examination of the child as well. Alleged child abuse victims may be interviewed in a school setting without consent of the parents.

3–19. Medical examinations

a. The MTF commander will ensure that a physician or other health care professional (including, when appropriate, a dental officer) is made available as soon as possible after receiving the initial report of abuse to examine all victims of alleged spouse or child abuse.Depending on the circumstances of the particular case, the medical examination may occur before, during, or after the time the victim provides information about the abuse. With young child victims, the medical examination may constitute the only evidence of abuse. In child sexual abuse cases, the medical examination may be required to corroborate information provided by the victim. In either instance, a prompt medical examination performed by a competent physician will usually be essential. The examination may include a colypsopic examination by a qualified physician.

b. Unless otherwise required by applicable law, parental consent is not required for medical examination, treatment, or hospitalization of a victim of child abuse in the MTF when one or both of the parents are suspected of inflicting the abuse or in concealing information about the abuse. However, FAP personnel have no individual authority to remove a child from a home, school, or CDS or YS facility for the purpose of hospitalization or medical examination or treatment unless a bonafide emergency exists or the child is 18 years or older and consents to hospitalization, medical examination or treatment. In the absence of these circumstances, first obtain judicial authorization or the assistance of local civilian authorities (e.g., CPS) before attempting removal. When this is not possible or feasible, consult the supporting SJA. All legal efforts should be exhausted in order to avoid leaving a child alone with a parent suspected of having abused the child.

c. Photographs, both color and black and white, will usually be necessary in cases of child physical or sexual abuse and in some cases of child neglect to substantiate medical findings and to corroborate information, if any, provided by the victim. Law enforcement personnel have the primary responsibility for taking photographs in abuse cases. If such photographs are not taken, MTF personnel will take such photographs during or following medical treatment.

d. The MTF will develop written protocols that address the following—

(1) Spouse abuse.

(a) Initial treatment and follow-up. This includes inpatient and outpatient medical care for physical injuries sustained by victims of spouse abuse.

(b) Clinical evaluation. Clinical evaluation will be performed as soon as spouse abuse is suspected. MTF staff will screen medical records for indications of previous abuse and check Central Registry data to ascertain the existence of previous reports of abuse.

(c) Collection of forensic information and evidence. Evidence of spouse abuse will be documented. Photographs should be taken by medical or law enforcement personnel in order to document visible injuries.

(2) Child abuse.

(a) Clinical evaluation. Clinical evaluation of children and their families will be initiated as soon as child abuse is first suspected. MTF staff will screen medical records of all family members for indications of previous abuse, arrange for medical evaluation by a pediatrician, and request the Army Central Registry to conduct a check for previous child abuse.

(b) Collection of forensic information and evidence. Evidence of child abuse will be collected through documentation.The attending physician will carefully record all observations, to include description of the child's general appearance and the location of bruises, contusions, fractures, or other injuries. The size, color, and location of injuries will be documented on a body chart or similar drawing. When appropriate, photographs will be taken as soon after the abuse as possible and again approximately 30 hours after the incident when full coloration appears. (See para 3-19c on the responsibility for photographs). Photographs will show the patient's name and the date taken. The signature of the physician and the photographer will be written on the back of the photograph.In cases of severe bruising, obtain coagulation studies. Obtain a detailed account of how injuries were reported to have occurred from the person who brings the child to the MTF. Record this information on appropriate medical forms and file in the CRC file. Other recorded information should include laboratory data, X-rays, and consultation reports as indicated. Coordinate evidence collection with law enforcement authorities. On occasion, it is necessary to examine the victim's home or place where the alleged incident occurred in order to complete the

forensic evidence and gain valuable information about the child's living environment. In most cases, this visit to the crime scene is conducted by law enforcement personnel. However, when it is necessary for social workers to visit the victim's home to obtain additional information about the child's living environment, the Chief, CRC may designate a case manager to conduct the home visit.

(c) Child sexual abuse evaluation. Each MTF should have the capability to collect evidence in child sexual abuse cases. MTF staff and law enforcement agencies will determine the need for forensic examinations, cultures, or radiological surveys. Documentation of genital and anal injuries should be made on appropriate diagrams. All child sexual abuse evaluations must have the following types of assessment, if applicable, as part of the MTF clinical workup—

1. Psychological assessment of each parent to determine his or her mental status, personality, parenting capabilities, psychiatric problems, and potential for harming any child in the family.

2. Psychological assessment of the suspected victim to determine the child's mental status, psychiatric problems, and potential to develop psychological problems.

3. Psychological assessment of siblings to prevent and identify any self-abuse, suicidal or homicidal potential.

e. Mental health personnel, social workers, CPS caseworkers, medical personnel, and law enforcement personnel should carefully coordinate the diagnostic interviews to avoid duplicating diagnostic efforts in identifying spouse or child abuse.

f. Clinical data on the psychological status of the parents and suspected victim will be integrated with medical data, legal data, and CPS agency data. In no case should a suspected child sexual abuser be cleared on the basis of polygraph data alone. Any discrepancies between what the parent says versus what the victim says need to be carefully assessed and documented.

g. In all cases of suspected child sexual abuse where the child victims are 10 years of age or younger, the clinician doing the assessment will report his or her tentative findings, if any, as to whether or not sexual abuse occurred, and the clinical indicators for that conclusion. Such clinical reports should contain as many details, facts, and clinical observations as possible. A comprehensive clinical report allows the CRC to manage the case most effectively.

3–20. Search authorizations

a. Personnel responding to initial reports of spouse or child abuse on Army installations should attempt to obtain as much evidence and other information as possible about the alleged incident, including any physical evidence that may clearly corroborate or rebut the report of abuse.

b. Regardless of whether the CPS (pursuant to an MOA with an off-post jurisdiction) or the SWS is initially involved in investigating a report of abuse on an Army installation, the military police or USACIDC, as appropriate, will promptly be notified by the investigating agency or instrumentality in any instance when physical evidence related to the report of abuse is expected to be recovered.

c. Under M.R.E. 315, MCM 1984, some Army commanders, military judges, and part-time military magistrates have the authority to order the searches of soldiers and their quarters on the military installation based on probable cause. In foreign countries such searches may be conducted off the installation when permissible under the governing Status of Forces Agreement (SOFA). The supporting SJA ordinarily should be consulted prior to requesting a commander, military judge, or part-time military magistrate to issue a search authorization.

3–21. Questioning soldiers and civilians suspected of offenses involving spouse or child abuse

a. Under Article 31, UCMJ, a person or civilian agent of a person subject to the UCMJ may not question a soldier suspected of an offense "without first informing him of the nature of the accusation and advising him that he does not have to make any statement regarding the offense of which he is accused or suspected and that any statement made by him may be used as evidence against him in a trial by court-martial." In addition, prior to questioning, a soldier suspect must be advised of his or her right to counsel as set out in M.R.E. 315, MCM 1994.

b. The requirement to advise soldiers of their rights under Article 31, UCMJ, prior to questioning does not apply to a situation in which the questioning is conducted by foreign authorities and is neither instigated by nor participated in by military personnel or their agents. However, other constitutional or statutory rights advisement requirements may apply. Consult the SJA for these, and any applicable SOFA provisions.

c. The law enforcement agency with jurisdiction in the case has the primary responsibility for the formal or informal questioning of soldiers and civilians suspected of spouse or child abuse. The USACIDC should perform the initial questioning if the suspected abuse occurred on an Army installation. In foreign countries, if the abuse occurred off the installation or involved civilians, existing agreements may require appropriate involvement of host nation law enforcement agencies. In the United States, a CPS agency investigating child abuse on an Army installation pursuant to a MOA between the installation and a local jurisdiction may question soldiers suspected of child abuse without military police or USACIDC involvement, but must conduct such questioning in accordance with law and procedures otherwise applicable to the CPS agency involved.

d. Except when not required by law or when delay would likely result in an immediate threat to the life or safety of an abused child, soldiers suspected of spouse or child abuse will be advised of their rights under Article 31, UCMJ, and of their right to counsel prior to being questioned about abuse offenses. Soldiers who are self-referrals will also be advised of their rights under Article 31, UCMJ, and of their right to counsel prior to being questioned about abuse offenses. The Army policy on self-referrals should also be explained to them, but should not be used as an inducement to persuade soldiers to waive their rights under Article 31, UCMJ.(See para 3-28 on the Army policy regarding self-referrals.)

e. Military social workers and MTF personnel must immediately notify the military police or USACIDC when a child or witness discloses child abuse or when they suspect that a criminal offense may have occurred, whether or not substantiated. Social workers are not law enforcement officials gathering information for an investigation. Their primary concerns are protecting the victim from further harm, gathering information concerning the psychosocial and family dynamics in order to develop effective treatment plans and providing the necessary support services. Once a determination has been made that an active duty member is the alleged offender, the social worker or medical personnel should not attempt an interview without first contacting law enforcement personnel.When a soldier walk-in or self-referral discloses to a social worker or medical personnel that he/she physically or sexually abused a family member, the social worker should at this point stop the interview and contact the military police or USACID for advice pertaining to proper rights advisement.A civilian is not subject to Article 31, UCMJ, and therefore does not have to be advised of his/her rights by a social worker or medical personnel(military or civilian). Generally, if the purpose of the interview is purely health care, there is no need for a health care professional to provide a civilian suspect a rights warning of any sort. However, this is not always the case. Health care professionals should coordinate with the SJA prior to interviewing civilian suspects to determine the current status of the law with regard to providing rights advisements. In the case of joint interviews, the lead in the investigative process rests with the law enforcement agent. Any rights warnings should be read by law enforcement personnel because, in joint interviews, the separation of function between the social worker or medical personnel activities and the criminal investigation is not always apparent.

3–22. Findings of fact

a. Every report of spouse or child abuse will be promptly and fully investigated. The CRC, after considering each report of abuse, will make and enter findings on DD Form 2486 that the abuse is either substantiated or unsubstantiated. If further information is required before such findings can be made, the CRC may reschedule

the case to a later CRC meeting until sufficient information is available to make such a finding, but in no case should a determination be delayed more than 60 calendar days.

b. CRC findings are clinical decisions, not criminal determinations. The CRC is an advisory team which can make recommendations to commanders, supervisors and courts regarding administrative and disciplinary actions for perpetrators of child/spouse abuse. The purposes of the CRC are to identify whether someone has been the victim of abuse, to determine if the victim is at immediate risk of further trauma, coordinate the necessary support services to protect the victim and ameliorate the situation. A CRC finding identifying an alleged offender may cause a commander or supervisor to pursue administrative or disciplinary measures against that individual, who is then entitled to the full range of due process rights afforded in those proceedings. Because CRC findings are used within the FAP for the purpose of providing services and developing treatment plans for families, there is no right for soldiers or family members to be present at CRC meetings while their cases are being discussed. CRC findings may not be used outside the FAP as the sole basis for denying a person an opportunity for employment or for taking adverse actions. However, the information upon which such findings are based, together with information gathered from other sources (e.g., military police reports, statements by the alleged abuser or witnesses) may provide the basis for taking such actions.

Section V
Protection of Spouse and Child Abuse Victims

3–23. Medical protective custody of child victims

a. Circumstances requiring immediate measures to protect a child abuse victim may arise before the alleged abuser is apprehended or questioned. Unless otherwise prohibited by applicable law, a physician treating an abused child on a military installation may take the child into medical protective custody without parental consent if the circumstances or condition of the child are such that allowing the child to remain in the care or custody of the parent presents imminent danger to the child's life or health. Although parental consent for medical protective custody should normally be obtained, subparagraphs b through d below, establish the procedure to be followed when parental consent has not been obtained and the child has been properly delivered to the MTF for medical treatment (See para 3-19b for restrictions on moving a child to a MTF without parental consent). Law enforcement personnel should always be involved in any questioning of the parent or parents suspected of abuse or of concealing information about the abuse.

b. The treating physician will make the initial determination that medical protective custody is required. That determination is subject to approval by the MTF commander following consultation with the supporting SJA. The MTF commander will ensure that the CRC chairperson, the law enforcement or CPS agency having jurisdiction in the case, and the suspect's unit commander are notified immediately so that appropriate judicial or command action to protect the child following the period of medical protective custody can be implemented in a timely manner.

c. The standard to be applied in determining whether to take medical protective custody of a child is whether the child suffers from abuse or neglect by a parent to the extent that immediate removal from the home is necessary to avoid imminent danger to the child's life or health. If applicable law establishes a different standard, then the standard required by that law shall be applied. The following are some examples of situations in which a MTF commander may approve medical protective custody for a child—

(1) The child's parent refuses to permit the child to receive immediate medical care for a condition which seriously endangers the child's life or health, and there is a suspicion that the parent may flee with the child or refuse to comply with ongoing medical treatment.

(2) The child's parent is physically or psychologically impaired to the point that he or she is otherwise unable to care for the physical needs of the child or to adequately protect the child.

(3) The child would return to the care of a parent who absolutely refuses, or is unwilling to supply the minimal necessities of food, clothing, or shelter.

(4) The child's parent plans to place the child in the company of a person or persons who, in the CRC's judgment, are likely to physically injure or sexually abuse the child.

d. The case manager will immediately inform the child's parents when the MTF commander retains a child in the hospital under medical protective custody.

e. Arrangements for admission to a civilian or other military hospital will be made if the MTF does not have inpatient capability to admit children requiring medical protective custody. Prior to transfer, the physician will notify the CRC chairperson unless urgency dictates otherwise.

f. The physician will consult the CRC chairperson before a child in medical protective custody is discharged from the MTF. If the parents want to remove the child from the MTF against medical advice, the attending physician will notify the military police, contact the CRC chairperson and obtain advice from the SJA. (See para 3-25b(5)(b) on emergency foster care procedures.)

3–24. Protection of abused spouses

a. Responding to reports of ongoing domestic violence is the responsibility of law enforcement agencies. Law enforcement personnel arriving on the scene will immediately stop the violence and protect the abused spouse from further harm.

b. The installation MOA and military police SOPs will require a priority response to reports of family violence and will require the military police to file written reports of all such incidents.

(1) Military police responding to a report ofdomestic violence may take a variety of immediate measures to stop the violence and protect the abused spouse, depending on the circumstances. For example, the military police may attempt to mediate the dispute, or may simply separate the spouses to end the violence.

(2) Apprehension of one or both spouses ordinarily is appropriate in all situations involving serious injury, use or threatened use of a weapon, violation of a court protection order or command imposed order of restriction, or other imminent danger to either individual.

c. In all situations where a suspected abuser is apprehended, the military police will document all evidence in accordance with established procedures and regulatory requirements. Ordinarily, a written statement (preferably handwritten) should immediately be taken from the victim. The statement should indicate the frequency and severity of any prior incidents of physical abuse by the abuser, the number of prior calls for assistance, and, if known, the disposition of those calls. The military police report should contain as much detail about the incident as possible to include observations of the victim, abuser, visible injuries, weapons present, whether children were present or harmed in any way, and any other circumstances or facts significant to the abuse situation. When possible, the report should include photographs taken of property damage or any personal injuries sustained by the victim.

d. Regardless of whether or not an apprehension is made, the military police will interview the spouses separately so that each spouse can speak freely without being inhibited by the presence of the other.If either spouse chooses to leave the quarters, the military police should stand by to preserve the peace, and remain in the home for a reasonable period of time to allow the departing spouse to remove personal and necessary belongings. In all cases the victim will be informed about the FAP and about a shelter or other available victim assistance services. The military police will also arrange or provide transportation for the victim to a shelter, MTF, or other appropriate victim assistance agency.

e. The military police will notify the RPOC on a daily basis of all reports of spouse abuse received by the military police.The notification procedures, whenever possible, should be included in any MOA with local jurisdictions regarding reports of spouse abuse occurring off the military installation.

3–25. Long-term protection of abuse victims

a. The installation commander is responsible for ensuring that procedures exist to protect victims of abuse following the report of abuse and approving measures that will serve to protect abuse victims from further harm. Such actions should only be taken after consultation with the CRC and supporting SJA.

b. The following measures may be considered when protecting victims of spouse or child abuse.

(1) Pretrial restraint. Under R.C.M. 304, MCM, a soldier suspected of spouse or child abuse may be ordered by his or her commander to refrain from doing specified acts as a condition of remaining at liberty or to remain within specified limits. Such forms of pretrial restraint may be appropriate in both spouse and child abuse cases. For example, a commander may order a soldier to stay away from his or her military or civilian family quarters for a specified period of time, or the commander may order the soldier to have no personal contact with an alleged abused victim for a specified period of time. If appropriate, the soldier may be restricted to the specified limits as designated by his commander or have pass privileges revoked. Pretrial restraint may be appropriate for a solider who has threatened further harm to abuse victims or when the commander has reasonable grounds to believe that the soldier will intimidate the abuse victim or otherwise obstruct justice. Some form of pretrial restraint is usually appropriate in a child sexual abuse case where a soldier parent has been removed from the home to protect the victim from further abuse or possible intimidation. Removing the suspected offender from the home, rather than the child victim, is the preferred means of protecting the child in such cases.

(2) Pretrial confinement. Under R.C.M. 305, MCM, a commander may order a soldier into pretrial confinement if the commander has reasonable grounds to believe that the soldier committed an offense triable by a court-martial and confinement is necessary to prevent the soldier from committing further serious criminal misconduct and less severe forms of restraint are inadequate.

(3) Removal from government family quarters. An installation commander has authority to remove entire families, or members offamilies, from government family quarters on the installation (including government-leased quarters off the installation).

(a) Removing an entire family from government quarters is not appropriate unless such a measure is the only means available to protect a child abuse victim from further abuse on an Army installation where a local jurisdiction refuses to exercise jurisdiction over the case.Otherwise, commanding officers should ensure that innocent civilian family members are not removed from government family quarters solely because they were victims of an abuse incident. Close supervision by the CRC of a family on the installation is preferred in most instances.

(b) Removing individual civilian members of a family from government quarters may be an appropriate means of protecting a military spouse or minor children from further abuse. In cases of spouse abuse where there are no minor children, removal of the civilian spouse abuser from government family quarters will in effect terminate the quarter's assignment of the abused soldier.

(4) Bar from installation. A commander of an installation in the United States has the inherent authority to permanently bar any civilian from entering the installation, regardless of whether or not the installation is generally open or closed to public access. A bar order can be imposed on a civilian spouse or parent whose continued presence on the installation represents a threat to the safety of any adult or child living on the installation. Violations of bar orders are crimes (18 U.S.C. Section 1382) which are separately punishable before a Federal magistrate or Federal district court judge.

(5) Foster care. The Army Foster Care Program is described in AR 608–1, chapter 9. In order to place an abused child in foster care, the consent of one of the parents is required or, in the absence of consent, the appropriate state or foreign court having jurisdiction in the case must authorize foster care. In the United States, the local CPS or courts will usually assist in placing children in foster care when parental consent is not given. In foreign countries, access to courts may be more difficult. The installation MOA, and the MOA, if any, with local authorities should describe the procedures to be followed to obtain court authorization to place children in foster care.

(a) Procedures. When the CRC determines that abuse is substantiated, a child is at risk of death or serious injury, and foster care is required, placement will be accomplished whenever feasible through the judicial system of the state or host nation having jurisdiction over the child. In the United States, the CRC through the CPS will seek judicial authorization even in cases where the parents of the child have consented to foster care. In foreign countries, CRC will utilize the judicial system of the host-nation court having jurisdiction over the child in appropriate cases, following coordination with the Local Liaison Authority. See Chapter 7 on the transfer of child abuse cases designated as"threat-to-life" and "foster care" cases.

(b) Emergency foster-care. In situations where judicial authorization or parental consent for foster care cannot be obtained, or cannot be obtained in a timely manner, and medical protective custody is not appropriate, an installation commander may authorize emergency foster care when abuse is substantiated and the child is at risk of death or serious physical injury. However, as with medical examinations without parental consent, FAP personnel have no independent authority to remove a child from a home, school, or CDS, or YS facility. (See para 3-19b on the restrictions on taking a child to a MTF without parental consent.) In foreign countries, FAPM will consult with the supporting SJA on the procedures to be followed in authorizing emergency foster care, but such foster care should only be authorized on a temporary basis pending judicial authorization from a court having jurisdiction over the case. Emergency foster care may be necessary, not only in cases of physical abuse, but also in cases where children have been abandoned or are at risk for sexual abuse.

(6) Overseas command actions. In some cases, long-term protection of spouse and child abuse victims may not be possible in overseas commands. The following measures may be appropriate to protect child abuse victims when judicial authorization or parental consent cannot be obtained, and in spouse abuse cases when necessary in the interests of the command or the parties concerned.

(a) The overseas commander or designee may issue a letter of warning to the abuser.

(b) When abuse is substantiated and the abuser is an employee of an appropriated fund instrumentality, nonappropriated fund instrumentality, private organization, or government contractor, the overseas commander may notify the abuser's supervisor provided that the nature of the abuse reflects on employment qualifications.

(c) The overseas commander or designee may order the advanced return of civilian family members of soldiers and employees to the United States.

1. If a family member refuses to depart, his or her entitlement to logistical support (i.e., post exchange and other privileges) may be terminated. Medical care at the MTF, access to the commissary, and entitlement to enrollment in DODDS may not be terminated. The sponsor's assignment to government family quarters may also be terminated and the family member may be barred from entering specified U.S. Army installations.

2. In appropriate cases, the appropriate commander or designee may request host-nation authorities to remove a civilian family member (or employee or retiree) from their country if such person refuses to leave voluntarily and his or her continued presence will probably result in more criminal misconduct in the host country and lead to greater embarrassment to the United States.

(d) The overseas commander or designee may curtail the soldier's military tour of duty in the foreign country and order his or her return to the United States. This will usually, but not necessarily, mean that the family member involved in, or victimized by the abuse will return with the soldier to the United States where the courts are more readily available to address the abuse problem and protect the abuse victim.

Section VI
Treatment of Spouse and Child Abuse

3–26. General

a. Treatment includes intervention and therapeutic services designed to prevent repetition of abuse and restore the health of victims and innocent family members who have suffered physical or psychological damage from abuse. Treatment may also include crisis intervention, educational programs, short-term counseling, marital and family therapy, and support groups.

b. The primary goal of FAP treatment of spouse and child abuse cases is rehabilitation. However, certain cases of abuse, by nature of their repetitiveness and severity, are not amenable to treatment.Treatment does not preclude disciplinary and administrative actions against offenders in appropriate cases.

c. Army MTFs have the primary responsibility for treatment of victims and offenders. Other available and appropriate professional resources, both military and civilian, should be used to rehabilitate families.

3–27. Rehabilitation of soldiers

a. When an allegation of abuse against a soldier is substantiated, the CRC will review the case material and make recommendations to the soldier's command regarding the soldier's participation in FAP treatment. Commanders will consider the following criteria—

(1) The soldier's service record and any demonstrated potential for further service.

(2) A treatment prognosis from the CRC.

(3) Recognition by the abuser that the behavior was wrongful, an acceptance of personal responsibility for that behavior, and the expression of a genuine desire for treatment.

b. In the area of child sexual abuse, commanders should distinguish abusers from within the family from other sexual offenders when determining appropriate action. The soldier who is accused of child sexual abuse within the home may be more responsive to rehabilitative efforts and treatment. In such instances, providing treatment services may benefit the victim and family.

c. Many abusers are soldiers who are highly skilled and have a history of solid performance. When treatment is determined to be appropriate, unit commanders will direct that soldiers attend treatment and counseling sessions. Commanders retain the authority to initiate punitive or administrative action against soldiers under their command.

d. Relocating soldiers during treatment sometimes interferes with the successful completion of a treatment plan and may not in the best interest of the soldier, family, or the Army. The move may exacerbate the family's problems or place the victim at further risk without adequate support systems. This is particularly true when soldiers are being assigned to overseas commands. CRCs must communicate with commanders on particularly sensitive cases, review personnel levy rosters and be aware and follow case transfer procedures outlined in Chapter 7. The CRC and commanders must work cooperatively to stabilize open FAP cases.

e. Soldiers whose commanders do not recommend or concur with FAP treatment or who fail to progress in treatment will be considered for separation under provisions of AR 635–200 (for enlisted soldiers) or AR 635–100 (for officers) unless disposition of charges by court-martial is being considered or has been initiated.

(1) A failure to progress in treatment occurs when the abuser commits a subsequent act of abuse, fails to attend prescribed treatment sessions, fails to comply with prescribed treatment plans, or is otherwise unresponsive to treatment.

(2) Successful treatment occurs when there is an absence of abuse for a period of 12 months, regular attendance at required counseling and program sessions is demonstrated, and prescribed treatment goals have been met.

3–28. Self-referrals

Abusers should be encouraged to seek assistance through self referral. Soldiers who seek treatment or assistance for abuse problems may initiate the evaluation and intervention process by voluntarily disclosing the nature and extent of their problem to their unit commander, or FAP counseling personnel.

a. Admission of abuse by the abuser is sufficient evidence to require notification of the soldier's unit commander when disclosure is made to an individual other than the unit commander. (See para 3-9 on the requirement to notify unit commanders in all abuse cases).Disciplinary or administrative action against a soldier is not precluded by self-referral.

b. The fact that the soldier not already under investigation for spouse or child abuse voluntarily disclosed such abuse may be considered when determining whether disciplinary or administrative action against the soldier is appropriate. Voluntary disclosures of spouse or child abuse by a soldier do not preclude the Army from taking adverse action or reporting the abuse to state authorities pursuant to a MOA, nor do they protect the soldier against possible civilian judicial actions, criminal or civil.

c. Any information disclosed in response to official questioning, or in connection with any military or civilianinvestigation, shall not be considered information disclosed for the purpose of self-referral for treatment or assistance.

d. A voluntary disclosure of a past incident of abuse during an unrelated clinical counseling session should be handled on a case-by-case basis.

3–29. Communication with commanders

a. The case manager or responsible counselor will—

(1) Initiate and maintain communication with the unit commander. This requires the following—

(a) Written notification of the incident. Figure 3-1 shows a suggested format for notifying the unit commander that a report has been made and is being investigated. Figure 3-2 illustrates notification made to a commander regarding the case determination and recommended treatment services.

(b) Written outline of the treatment plan and team recommendations.

(c) Reports on the soldier's attendance and cooperation with the treatment plan.

(d) Evaluation of soldier's progress in treatment.

(2) Notify the unit commander of any subsequent acts of abuse or any failure to participate in the prescribed treatment plan.

b. The unit commander will notify the case manager of—

(1) Pending disciplinary or administrative action.

(2) Subsequent acts of abuse.

(3) Unit activities which impact on treatment.

(4) PCS/ETS of the soldier.

3–30. FAP treatment services

Each installation is required to ensure the following services are available to soldiers involved in cases of abuse and their families.

a. Services for children and families. Services that foster changes in parental behavior, parent-child relationships, home environment, and those that offer the abused child protection and treatment for physical and psychological damage will be provided by the MTF.

(1) Installations are required to provide case management, counseling, and foster care services or have MOAs with civilian agencies for these services.

(2) Respite day care, support groups, and other relevant services are to be provided based on an installation needs assessment and available resources. Respite day care provides temporary child care relief to family members and other caretakers of children who may be at risk of abuse or neglect. Respite care such as Mother's Day Out or child care services can be planned and act as a preventive service. In an emergency situation, short-term crisis care for abused or neglected children can be provided in child care settings. The FAP manager will develop local procedures and accountability measures when OSD funds are used to support respite care. The FAP manager will approve families for respite care in conjunction with the Chief, CRC.

b. Services to address child sexual abuse. Each installation MTF

must either have or have access to treatment staff trained to address child sexual abuse.

(1) All youth victims or perpetrators eligible for MTF treatment in child sexual abuse cases will receive appropriate treatment.Data concerning youthful offenders, age 11 and above, will be identified in the Central Registry by submission of a form DD 2486. All other cases involving youthful offenders, ages 10 years and under, will be forwarded to a special review team established by HQDA (CFSC–FSA). The special review team will review each case and determine whether identifying information on the offender should be submitted to the Central Registry on DD Form 2486. The CFSC review team will include, at a minimum, the HQDA FAPM, OTSG Social Work Consultant, OTSG Psychiatry Consultant, a representatives from OTJAG and USACIDC.

(2) Installation program services must include treatment for the offender and members of the family separately and jointly as needed, individualized treatment plans and monitored program participation. The CRC will report program progress, program completion and program failure to the commander periodically.

c. Programs to address spouse abuse.

(1) Abused spouses. A basic program for abused spouses will include—

(a) Crisis intervention.

(b) Counseling.

(c) Emergency housing accommodations and temporary shelter. The shelter arrangement or emergency accommodation used will depend on the situation and the installation resources. If the abuser is a soldier, the commander can order him or her to move into unit controlled barracks, place conditions on the soldier's liberty or direct the soldier to remain within specified limits, pending disposition of the offenses. Civilian shelters, transient billets, temporary quarters or an installation shelter or safe house system also may be used.

(d) Support services, such as legal service, financial counseling, housing and employment referral assistance as part of the overall treatment plan.

(e) Support groups that reduce isolation and foster self-confidence by providing interaction, support, and special information.

(2) Abusive Spouses. SWS will establish a program for abusers stressing the goals of stopping the abuse and accepting personal responsibility for behavior. Treatment models that view abuse as a learned behavior and stress the abuser's ability to learn self control and develop behavioral alternatives will be implemented by the MTF SWS, (e.g. batterer's or violence management groups.)

d. Services to address out-of-home child abuse.The MTF will provide counseling and support services to victims of out-of-home child abuse and their families and to abusers who are caregiving staff who are authorized treatment at the MTF.

3–31. Treatment for civilians

Civilian family members of active duty soldiers, retired soldiers, and DOD civilian employees and family members who are authorized treatment at a MTF should be offered counseling or other appropriate intervention by the MTF to the extent that resources are available. Their participation in FAP is voluntary. Commanders should encourage family member involvement in the treatment process.

3–32. Reassignment, deletion, or deferment

a. The CRC will make a timely recommendation to unit commanders on the prognosis of soldiers and family members in treatment as a result of spouse or child abuse.

b. In appropriate cases, a soldier may request or a commander may recommend reassignment or the early termination of a duty assignment in a foreign country, when reassignment is the only means to provide treatment to a soldier or family member or to protect a victim from further abuse. The soldier or unit commander may also request the soldier's deletion or deferment from reassignment in appropriate cases when reassignment would prove detrimental to the progress of the soldier or family member receiving professional counseling or treatment for spouse or child abuse (See AR 614–200, chap 3; AR 614–30; DA Pam 600–8–10; and paras 7-6 and 7-7b of this regulation for the appropriate procedures to be followed).

c. Requests for deletion, deferment and reassignment will be submitted to PERSCOM according to procedures outlined in DA Pam 600–8 paragraph 3-30, with appropriate documentation and a copy of the initiating memorandum to HQDA (CFSC–FSA), Alexandria, VA 22331–0521. Appropriate documentation is—

(1) Statement from the commander identifying any personnel action taken against the soldier and containing a recommendation as to the disposition of the request.

(2) Professional diagnosis/assessment of the case as a "threat-to-life" or "foster care" case and prognosis of the family problem from the CRC chairperson.

(3) Supporting letters or assessment summaries from specialists (e.g., pediatrician, psychologist, psychiatrist, certified family therapist, social worker, chaplain) or other professional persons working to assist the family.

(4) Summary of data on the sponsor and spouse's extended family (when assignment close to relatives is requested).

d. Routine cases will not ordinarily requirereassignment, deletion or deferment; however, each request submitted will be reviewed individually.

e. Upon PERSCOM approval of deletion, the soldier will be stabilized in the current assignment for one year. However, the soldier will be considered available for immediate assignment at the end of the stabilized period unless a request for extension of the stabilization is submitted by the soldier and approved by PERSCOM. The request should include—

(1) Documentation from the CRC chairperson that the soldier or family is progressing in treatment and requires only limited additional treatment.

(2) A statement provided by the unit commander indicating that the soldier has a good service record and demonstrated potential for further service.

f. Soldiers who do not meet either of the criteria in subparagraph e should be considered for elimination.

3–33. Treatment referrals to CPS

The CRC will not close a case which the local CPS agency has accepted unless the case is transferred to another jurisdiction. The CRC will follow the procedures prescribed in Chapter 7 of this regulation when a case is transferred to another civilian jurisdiction. CPS acceptance of a case does not relieve the CRC of the responsibility to ensure that adequate protection and necessary services are provided. At a minimum, a CRC case manager will be assigned to serve as liaison to the CPS. The case manager will—

a. Notify the unit commander of case progress.

b. Coordinate services to ensure maximum use of the military medical facilities.

c. Monitor progress toward treatment goals.

d. Staff the case with the CRC.

e. Provide all available records and information to the guardian ad litem when one has been appointed by a court.

f. Provide all additional records and information to CPS, as they become available, to ensure that the court has up-to-date and complete information on the case.

g. Coordinate all requests from a civilian court for witnesses, affidavits, and physical, documentary, and medical evidence with the SJA. All communications on these matters should be attorney-to-attorney--that is, between the lawyer designated in the SJA office to serve as liaison with local civil authorities (in accordance with para 1-7k(14)) and the lawyer handling the court case from the state, county, or district attorney's office.

(OFFICE SYMBOL)

MEMORANDUM FOR Commander, ***(Personal and Confidential) (Soldier's unit address)***

SUBJECT: ***(Names, SSN)***

1. The***(Installation name)***Case Review Committee (CRC) has received a report of (child abuse/neglect or spouse abuse) involving***(name of victim)***and ***(name of alleged perpetrator)***. The report alleges that (provide a brief description of the report, and include any existing documentation of physical injury and date treated).

2. A multidisciplinary assessment and investigation will be conducted and findings presented to the CRC for a determination. If determined unsubstantiated, the case will be closed and you will be advised. If determined substantiated, a comprehensive treatment plan will be developed and recommendations will be forwarded to you.

3. Involvement in the resolution of family violence is a command responsibility which is outlined in AR-608-18, para 1-7. You may contact ***(name of POC)***for further coordination at ***(phone number).***

(Signature block)
Chairperson, CRC

Figure 3-1. Sample memorandum notifying unit commander of alleged abuse

(OFFICE SYMBOL)

MEMORANDUM FOR Commander, ***(Personal and Confidential) (Soldier's unit, unit address)***

SUBJECT: ***(Names, SSN)***

1. The***(Installation name)***Case Review Committee (CRC) has received a report of (child abuse/neglect or spouse abuse) involving***(name of victim)***and ***(name of alleged perpetrator).***(if appropriate, note documented physical injury and date treated.

2. The CRC has conducted an investigation of this report and determined it to be ***(substantiated or unsubstantiated). (Name of the case manager)***has been assigned as the case manager, and will schedule and monitor treatement and follow-up determined by the CRC.

3. IAW AR 608-18, a DD Form 2468, Child/Spouse Abuse Incident Report, will be forwarded to U.S. Army Central Registry, Ft. Sam Houston, Texas (and, if applicable, to the county Child Protective Service or other agency name).

4. The CRC recommends ***(name of soldier)*** be command directed to report to ***(location)*** for treatment beginning***(date, time)***, and subsequently as scheduled. ***(name of case manager)***, the assigned case manager, may be contacted at***(phone number)*** for further coordination (include specific information on type, duration and purpose of treatment, and strongly encourage the spouse to participate).

5. POC for this correspondence is***(name, position, rank, phone number of CRC Chairperson).***

CF:

(Signature block)
Chairperson, CRC

Figure 3-2. Sample memorandum providing commander with CRC case determination andtreatment plan

Chapter 4
Disciplinary and Administrative Actions

4–1. General
The guidance in this chapter on disciplinary and administrative actions against soldiers accused of spouse or child abuse applies to all forms of spouse and child abuse occurring within the family. It does not apply to spouse or child abuse which results in the death of the victim or to any abuse which occurs outside the family, such as in a CDS setting (either quarters- or facility-based) or Youth Services. This chapter, like the other chapters, provides no procedural rights or privileges with regard to the processing and disposition of allegations of misconduct that are not otherwise provided by the UCMJ, the MCM or other regulations governing administrative and disciplinary actions.

4–2. Policy
The FAP includes a program of rehabilitation and treatment which does not preclude disciplinary and administrative actions as deemed appropriate by the soldier's commander against soldiers accused of spouse or child abuse.

4–3. Types of dispositions
a. Unit commanders must investigate allegations of spouse and/or child abuse according to provisions of AR 27–10, paragrah 3-14 and RCM 303, MCM. (See also para 3-15, this regulation, on requirement to notify military police when abuse is a criminal offense.)

b. Disposition of criminal offenses involving abuse can include the full range of administrative or UCMJ actions.

4–4. Considerations
a. Commanders should consider CRC recommendations, especially regarding rehabilitative potential, when taking or recommending disciplinary and administrative actions against soldiers which may be detrimental to the soldier's continued military career or future promotion opportunities, or to the financial or social well-being of his or her family members. Commanders are not required to delay the processing of such disciplinary and administrative actions to await the receipt of CRC recommendations. These actions include, but are not limited to, the following—

(1) Court-martial.

(2) Nonjudicial punishment (to include filing determinations).

(3) Letters of reprimand, including local or permanent filing determinations.

(4) Administrative discharge.

(5) Denial of reenlistment, including bars to reenlistment.

(6) Termination of government family housing. (See para 3-25b(3) on points to be considered in terminating housing.)

(7) Advance return of family members to the United States from overseas command. (See para 3-25b(6)(c) on procedures to be followed.)

(8) Bars to entering the military installation in conjunction with discharge or PCS. (See para 3-25b(4) on the use of bar orders.)

(9) Curtailment of the soldier's military tour or duty in the overseas command. (See para 3-25b(6)(d) on the procedures to be followed.)

b. Consistent with the interests of justice and the needs of the accused, the commander should consider the following before taking or recommending disciplinary and administrative actions against soldiers in spouse or child abuse cases—

(1) The seriousness of the alleged offense and the weight and availability of the evidence supporting it.

(2) Matters in aggravation or extenuation surrounding the commission of the alleged offense.

(3) Matters in mitigation including, but not limited to the following—

(a) The accused's military record and potential for further service.

(b) The manner in which the abuse was discovered(i.e., whether the abuse was uncovered during a self-referral or as a result of a report to or investigation by the military police.)

(c) The accused's potential for rehabilitation based on the recommendation of the CRC.

(4) The impact that disciplinary and administrative action against the soldier will have on his or her treatment.

c. When disciplinary or administrative actionagainst a soldier is determined to be appropriate, the commander should consider the recommendations of the CRC regarding retention of the soldier in the Army, protection of the victim from further abuse, and maintenance of the family.

d. When disciplinary or administrative action is contemplated against a soldier determined to be treatable who has demonstrated rehabilitative potential for further service, a commander may choose to take appropriate action to allow successful completion of a treatment program and continued service.

e. In overseas locations where Department of the Army civilians are involved, consult the local SJA.

Chapter 5
Army Central Registry

5–1. General
The U.S. Army Patient Administration Systems and Biostatistics Activity(PASBA), Fort Sam Houston, maintains an Army-wide, centralized data bank containing a confidential index of reported spouse and child abuse cases.This is referred to as the Army Central Registry and is used to assist in the early identification, verification, and retrieval of reported cases of spouse and child abuse.

5–2. Army Central Registry incident reporting procedures
a. DD Form 2486 is used to determine the existence of previous abuse reports; compile and analyze Army-wide statistics and management data; and provide background checks on individuals involved in ACS family advocacy programs, applicants, volunteers and employees in CDS and YS programs.

b. The CRC chairperson will submit a DD Form 2486 for every report of child or spouse abuse except as indicated in paragraph 2-4e. Multiple submissions of the report, e.g. an initial report, subsequent incident report, transfer, and case closure are required. Copies of all incident reports will be forward to—Director PASBA, ATTN: MCHI–QPD, CDR, AMEDD Center and School, 1216 Stanley Road, Fort Sam Houston, TX 78234–6127.

c. Abuse cases will be reported as follows—

(1) The CRC will prepare and submit an initial incident report form for every case, substantiated and unsubstantiated, reviewed. Privacy Act information (e.g. names, SSNs) will be excluded from reports pertaining to unsubstantiated cases. Data on unsubstantiated cases is used to determine workload only and is not used for identification purposes.

(2) Cases involving more than one victim in the same family will be reported separately. Mutual spouse abuse cases will also be reported separately.

(3) Cases involving youthful offenders will follow procedures outlined in paragraph 2-4e and 3-30b.

(4) The following procedures will apply for deciding sponsorship.

(a) In those instances where the mother and the father are both active duty military, the children will be reported under the abuser sponsorship (i.e., his or her social security number).

(b) In instances of mutual spouse abuse, a DD 2486 will be submitted for each person using his/her individual social security number.

(5) Cases of substantiated child abuse will be reported to the Army Central Registry though the offender may be unknown.

(6) A CRC case determination of substantiated or unsubstantiated is required prior to submitting the initial report. The initiation or completion of judicial or administrative proceedings against an alleged perpetrator, if one has been identified, is not required in order

to make a determination that a report is substantiated or unsubstantiated. Only the CRC's findings that abuse is unsubstantiated or substantiated will determine the case status of the victim.

(7) Incident reports should be completed by the CRC case manager and sent to the Army Central Registry for submission to the database within 10 working days following the CRC determination of case status. However in no case will the DD Form 2486 be delayed longer than 30 calendar days following determination of case status by the CRC. Subsequent transactions, e.g.supplemental reports, will be submitted within the same time frames.

(8) Locally retained copies of all written reports generated by the automated system to the Army Central Registry will be signed and dated by the Authenticating Official (Chief, Social Work Service, or Chairperson of the CRC) for the case files.

(9) If the CRC later determines that a case initially reported substantiated is actually unsubstantiated, the CRC chairperson will send the Army Central Registry a corrected incident report indicating the case number and the sponsor's SSN changing the case status to unsubstantiated.

(10) When the Army Central Registry receives the updated report, all identifying information pertinent to the sponsor and victim in the initial case on the Army Central Registry will be destroyed.

(11) For the purpose of submitting an initial or subsequent incident, reopened case, or transfer in which a case is to be closed, the following applies in designating the basis for closing the case—

(a) Resolved.

1. No subsequent incident of abuse has occurred within one year of the previously reported incident of abuse and treatment is deemed complete.Treatment is not deemed complete in an open case of abuse unless the CRC has determined that there is no further likelihood of abuse, or

2. Regardless of the length of time that has transpired since the previously reported incident of abuse occurred, the CRC has determined that abuse is not likely to reoccur because the victim and potential victims of abuse have been physically separated (other than on a temporary basis) from the alleged abuser (e.g., a death, divorce, or foster care placement has occurred). Cases may also be resolved when treatment is not required or is no longer required.

(b) Unresolved. A case is closed as"unresolved"when no subsequent incident of abuse has occurred within one year of the previously reported incident of abuse and treatment is incomplete because of lack of client cooperation or other reasons. A case will not be closed as"unresolved" if the CRC has designated the case as"threat-to-life" or "foster care." See paragraph 7-3b for case designation procedures.

(c) Separated from Service. A case is closed as"separated from service" when the sponsor or family member is no longer entitled to treatment in a MTF.

(12) Incident reports will be submitted on all out-of-home child abuse cases when the CRC determines a case is substantiated or unsubstantiated.

(13) Incident reports will be submitted on all fatalities if the CRC determines that the death was the result of an incident of child or spouse abuse.

(14) Report transfer transactions to monitor and track for continued services victims of substantiated abuse who move from or to another location.Closure transactions are considered only after treatment is deemed complete by the gaining MTF.

(15) The following applies when reporting case information to the Army Central Registry or documenting individuals who abuse victims ineligible for care in MTFs.

(a) The offender must be service connected, e.g.active duty, a family member, or a DoD civilian employee. Data must contain the offender's name and SSN.

(b) Sponsor data will not be included in the case information other than indicating the sponsor is "None of the Above".

(c) Victim name and SSN will be left blank.

5–3. Retrieval of Central Registry Information

The Army Central Registry is responsible for monitoring the access to and retrieval of case information. The local CRC chairperson is responsible at the local level for safeguarding case information according to law and regulation.

a. Processing Individual Requests

(1) Process requests submitted by individuals seeking information pertaining to themselves from the Army Central Registry according to the provisions of AR 340–21. Process requests submitted by individuals seeking information from the Army Central Registry pertaining to third parties according to the provisions of AR 25–55.

(2) Written FOIA or Privacy Act requests for Army Central Registry (ACR)records will be forwarded to the ACR. The written request must conform with the requirements of AR 25–55 and/or 340–21 and contain any other information that may be required to identify the requested records. If an individual other than the subject of the record makes the request, the requestor must provide, as part of the request, the subject's signed, written consent to release of the record.

(3) Written responses from the Army Central Registry will comply with FOIA and/or Privacy Act (PA) requirements and include a copy of the computer printout if the background check is positive.

b. Processing Official Requests

(1) The chairperson of the CRC will provide PASBA and the servicing MTF Chief, Patient Administration Division (PAD) office, with a list, updated periodically, of CRC representatives authorized to request Army Central Registry case information. These representatives will be limited to the CRC chairperson, the FAPM, and officially designated CRC case managers.

(2) Before information is released, the Army Central Registry and MTF PAD personnel will verify that the requestor is an officially designated CRC representative.

(3) The MTF PAD will develop local procedures for forwarding the requested information from PAD to the authorized CRC representative. These procedures will ensure that all transactions with the Army Central Registry are conducted by authorized personnel, are confidential, and are responded to within the prescribed time periods.

(4) Authorized CRC representatives may make telephone requests to the ACR. CRC requestors will provide the ACR with their names, duty title, duty addresses and duty telephone number, and the SSN of the subject of the record(victim, sponsor, and/or offender, as appropriate) and the basis for the request. Such requests will be made only in the performance of official duties and responsibilities and will not be made on behalf of individuals in their private capacity in lieu of a proper FOIA/PA request.

c. The Army Central Registry will conform to the following procedures when providing telephonic responses to CRC representatives. At the time of the call-

(1) The Army Central Registry will provide all existing records of child/spouse abuse on file directly to the authorized CRC representative.The ACR will send a copy of the computer printout through the MTF PAD to the requesting CRC representative.

(2) If no existing record of child/spouse abuse is on file at the ACR, the ACR will provide a negative response to the authorized CRC representative by telephone.

d. Pursuant to routine background checks, the Army Central Registry will check the following individuals for prior incidents of substantiated child/spouse abuse—

(1) Family Advocacy Program applicants, volunteers and employees.

(2) CDS and YS programs volunteers, applicants and employees.

(3) Family Child Care (FCC) applicants and current members of the applicants household above the age of 12.

5–4. Requests for statistical information

All requests for statistical information will be made according to AR 40–66. Information for research purposes must be requested through HQDA (CFSC–FSA), Alexandria, VA 22331–0521. Requests for statistical information on individual installations may be made

directly to the Army Central Registry by the Chief, SWS, Chairperson CRC or the FAPM.

Chapter 6
Records Management

6–1. General
This chapter (except for para 6-8) applies to all CRC files (AR 25–400–2, FN 608–18) that contain medical records of substantiated cases of spouse or child abuse, extracts from law enforcement investigative reports, correspondence, CRC reports, follow-up and evaluative reports, and other supporting data relevant to individual family advocacy case management files. Access to such records is governed by the same criteria as records maintained at the installation and at the Army Central Registry (See para 5-3).

6–2. Policy on sharing case-record information
To the extent permitted by applicable law and regulation, social workers, physicians, dentists, nurses, and law enforcement personnel, both civilian and military, may share investigative leads, information, and records to ensure that all facts are fully developed given the total resources and means available. However, because of the sensitive nature of such records, such individuals should exercise great care to ensure that information is disclosed only to those employees (military or civilian) of DoD who have a need for the information in the performance of their official duties. (See AR 340–21, chap 3.)

6–3. Establishment of the CRC file
a. A file will be prepared for each person treated or evaluated for suspected child or spouse abuse. The file will be maintained as directed by the chairperson of the CRC per AR 25–400–2, File No.608–18. The CRC file is under the administrative control of the MTF PAD. The file will be housed in and maintained by the MTF. If geographic distances or other considerations preclude this, alternate arrangements for housing and maintaining CRC files must be coordinated through the chain of command of the activity that will be assuming that responsibility and approved by the MTF commander. Unique local arrangements will be described in the installation MOA.

b. The CRC file will contain the following information and documents relating to the diagnosis, assessment, treatment and disposition of abuse—

(1) Standard Forms 600 (Health Record-Chronological Record of Medical Care) documenting each action and contact on the case.

(2) Copies of dental examinations, where appropriate.

(3) Copies of DD Form 2486 transactions submitted to the Army Central Registry.

(4) Summary of all case presentations to the CRC.

(5) Extract of CRC minutes.

(6) Copies of physical examinations.

(7) Social history.

(8) A family assessment.

(9) Community Health Nurse report (if applicable).

(10) Photographs.

(11) Copy of X-ray results (if applicable).

(12) Copy of blood and other test results.

(13) Extracts of pertinent data from the military police report, CID report, and other investigative reports.

(14) Copy of any pertinent legal records.

(15) Reports from local child or spouse abuse agencies.

(16) Clinical reports submitted by mental health personnel diagnosing and/or treating the soldier or the family.

(17) Other information pertinent to the case.

(18) Master problem list.

(19) Treatment plan.

(20) Copies of correspondence with the command.

(21) Documentation of each counseling/treatment session and telephone calls concerning the case.

(22) Limits of confidentiality and Privacy Act forms.

6–4. Access to records by individuals
a. Access includes the review of a record or obtaining a copy of the record or parts thereof.

b. An individual about whom a FAP record pertains will be granted access to the record unless—

(1) The Surgeon General has invoked an applicable exemption from the disclosure provisions of the Privacy Act (AR 340–21, chap 5) or

(2) The record is information compiled in reasonable anticipation of a civil action or proceeding. (See 5 U.S. Code section 552a(d)(5) for denying access on these grounds.)

c. Individuals requesting access to their records maintained at the installation may make a written or oral request to the MTF commander.Requestors should provide their full name, SSN, current duty address, date and location of treatment (or other details that will assist in locating the record) and signature. The PAD will forward request to the Access and Amendment Refusal Authority (AARA) (The Office of the Surgeon General)following coordination with the CRC chairperson for a releasability determination (See para 6-8 for access to medical records).

d. Process third-party requests (i.e.requesters seeking access to another person's records) under the provisions of AR 25–55, AR 340–21, and AR 40–66.

6–5. Access to records outside DOD
a. Records may be disclosed outside DOD without the consent of the subject individual for the routine uses included in the published system notice (See DA Pam 25–51, para 10-13(f).

b. The following disclosures outside DOD are contained in the published system notice and are compatible with the purpose for which the information was collected and maintained by the Army. Information may be disclosed to—

(1) Officials and employees of the components of the Department of Defense and other department and agencies of the Executive Branch of government in performance of their official duties relating to coordination of family advocacy programs, medical care and research concerning child abuse and neglect, and spouse abuse;

(2) The Attorney General of the United States or his or her authorized representatives in connection with litigation or other matters under the direct jurisdiction of the Department of Justice or carried out as the legal representative of the Executive Branch agencies;

(3) Federal, state, or local governmental agencies when it is deemed appropriate to use civilian resources in counseling and treating individuals or families involved in child abuse or neglect, or spouse abuse; or when appropriate or necessary to refer a case to civilian authorities for civil or criminal law enforcement.

(4) National Academy of Sciences, private organizations and individuals for health research in the interest of the Federal Government and the public, and authorized surveying bodies for professional certification and accreditation such as Joint Commission for the Accreditation of Hospitals.

c. In addition to those disclosures indicated in the system notice(subpara b above), the following blanket routine uses, among others, apply with regard to the release of information outside DOD (AR 340–21, para 3-2)—

(1) Law enforcement. Relevant records may be referred to an appropriate federal, state, local, or foreign law enforcement agency if the record indicates a violation or potential violation of the law.

(2) Congressional inquiries. Records may be disclosed to a congressional office in response to a congressional inquiry made at the request of an individual who is the subject of the record.Records should not be disclosed to a congressional office in response to a congressional inquiry made by a third party on behalf of the subject of the record without the express written consent of the subject.

6–6. Disclosure within DOD

The Army generally is prohibited from disclosing a Privacy Act record to a third party without obtaining the prior written consent of the individual who is the subject of the record. One exception to the general rule is a disclosure made to officers and employees of DOD who have a need for the record (or the information within the record) in the performance of their official duties. (See AR 340–21, para 3-1.) Such officers and employees may include commanders, trial counsel, and MP and USACIDC law enforcement personnel. The Army may disclose the applicable record, or the fact that no record exists on a particular individual, to the following persons for the stated purpose—

a. Authorized CDS personnel - for background checks on—

(1) Applicants for positions as FCC providers.

(2) Applicants for employment with child care facilities.

(3) Employees of child care facilities.

b. Authorized YS personnel - for background checks on—

(1) Applicants for employment in YS programs.

(2) YS program employees and volunteers.

c. Authorized family advocacy personnel for background checks on—

(1) Applicants and employees of family advocacy paid and volunteer positions.

(2) Foster Parents and respite care providers.

6–7. Disclosure pursuant to court order

A record will be disclosed pursuant to the order signed by a judge of a court of competent jurisdiction; however, reasonable efforts must be made to notify the individual who is the subject of the report if the legal process is a matter of public record. (see AR 340–21, para 3-lk). An order signed by a clerk of court on behalf of the judge or a subpoena signed by an attorney will not suffice. A court of competent jurisdiction may include any federal, state, local, or foreign court with jurisdiction to issue the order for the record in question. Confidential sources will be revealed when the court order so directs. Individuals receiving such court orders should consult with the SJA prior to release of information.

6–8. Special category records

a. The outpatient treatment record(OTR) or health record of individuals treated as a result of substantiated spouse or child abuse will be coded as special category records as authorized in paragraph 4-4(10), AR 40–66, if deemed necessary by the CRC. A record so marked must contain a SF 600, Chronological Record of Medical Care, with the diagnosis of spouse or child abuse. Records so designated must be hand carried by health care personnel between clinics and the records room. When a child with a record marked in such a manner is seen in a treatment facility, medical health care professionals should evaluate the child for further symptoms of abuse. If present, such symptoms should be documented in writing. A colored strip of tape will be placed in the empty block on the lower right edge of the front cover for suspected and substantiated cases. The file folder should also be marked with a colored 3x5 card attached to the upper right hand corner of the front of the folder with the following statement printed on it—"This record is a special category record."

b. When the CRC classifies a case as"substantiated", the CRC chairperson will notify the custodian of the OTR, who will ensure that both the medical and, where appropriate, dental OTR are properly coded.Also, when the CRC considers other family members associated with the case to be at risk, the chairperson will notify the custodian, Outpatient Treatment Records, who will ensure that the OTRs are color-coded in the same manner.

c. The appropriate CRC member will make a brief notation in all color-coded records stating the nature of the incident or injury.

d. When the CRC closes a case, the CRC chairperson will notify the custodian, Outpatient Treatment Records, who will ensure that a new DA Form 3444 (Terminal Digit File for Treatment Record) is prepared for each individual in the family who has a color-coded record. (Merely removing the colored tape is insufficient to ensure confidentiality because a mark will remain on the jacket due to adhesive utilized.) In an open case when a sponsor's family is being transferred to another duty station, the OTR(s)will be mailed to the gaining MTF (See AR 40–66, para 5-24).

6–9. Advice of SJA

The SJA will be consulted for advice whenever necessary to resolve legal issues involving access to FAP records or the disclosure of the identity of a confidential source.

Chapter 7
Transfer of Cases

7–1. General

This chapter outlines procedures for managing and transferring all open spouse and child abuse cases when the CRC has determined that abuse is substantiated; and,

a. The soldier or affected family members have moved away or will be moving away from the military installation having responsibility for handling the case and another CRC or a civilian agency should assume the responsibility of managing the case; or,

b. Relocation of the soldier jeopardizes the successful completion of treatment, will further exacerbate the family's instability or when adequate support services are not available at the new duty station.

7–2. Transfer of spouse abuse cases

a. Procedures for transferring routine spouse abuse cases include—

(1) A case transfer conference (para 7-3a) to discuss the plan for continued services and, when appropriate, the victim's plan for protection in the new location.

(2) Transfer of the CRC file (para 7-5).

b. The CRC is responsible for determining when a victim of spouse abuse is at risk of death or serious (i.e., life threatening) injuries and arranging for special protection during case transfer. To the extent that extraordinary measures are required for the continued protection of the victim, some of the procedures outlined in paragraph 7-7 can be adapted to fit the needs of the victim during the transfer process. Other measures, such as protective court orders, and advanced notification of appropriate law enforcement agencies also may be appropriate.

c. Patient Administration Division of the MTF may delegate authority to transfer records to SWS.

7–3. Transfer of child abuse cases

The following actions will be performed for all child abuse cases that are to be transferred.

a. Case transfer conference.

(1) A case transfer conference will be conducted between the family, the case manager, and other interested parties (e.g., commander, CPS, court representatives).

(2) The purpose of this conference is to discuss with the family the plan for continued treatment services and, in threat-to-life and foster care cases, military assignment actions. (See subparagraph b below for the definition of these cases). The plan should include, when appropriate, foster care and other services in the location to which the family is moving, and other measures outlined in this chapter which are necessary for the movement and treatment of the family and the continued protection of the victim.

(3) In abuse cases occurring in foreign countries, possible arrangements for transferring the abused child to the United States will be discussed, and parental consent for the transfer of the child in the custody of a CRC member from the overseas command will be obtained in appropriate cases whenever possible.

(4) If the abused child will not be accompanying the soldier to his or her next duty assignment, the new location of the child's anticipated residence will be obtained from the soldier in advance of the child's departure. In appropriate cases, the possibility that a state court will exercise or continue to exercise jurisdiction over the

abused child until arrangements satisfactory to that court are made in the new location for the protection of the child will be discussed with the family. Although in some cases it may be desirable to send the abused child to the new location separate from the parents, in no case will an abused child be retained in an overseas command after both parents have departed.

(5) In cases where a child has been abandoned in an overseas command, every effort will be made to place the child in a state or locality in which parents, or other relatives reside or have resided. When a child is to be transferred to a Child Protective Service agency in a particular state or locality, the CRC chairperson will inform that CPS of the proposed transfer before the child is escorted to the United States. An abandoned child will not be retained in an overseas command, in foster care or otherwise, unless required to be retained by an overseas command by order of a court of competent jurisdiction.

b. CRC designations. The CRC will classify and document in the case record and on the transfer letter all child abuse cases being transferred as either"threat-to-life" "foster care"or "routine". These designations may be made before or after assignment orders are published. In cases where foster care is required, the procedures in paragraph 3-25b(5) and 7-4 will be followed.

(1) Threat-to-life cases. These cases involve child victims of abuse who are at risk of death or serious (i.e., life-threatening) physical injury who require or will require immediate foster care or emergency measures(e.g., medical protective custody) to protect their lives. Cases involving sexual abuse alone are not threat-to-life cases.

(2) Foster care cases. These cases involve child victims of abuse(other than threat-to-life case) where, although the abuse is not life-threatening, foster care, or a continuation of foster care, nevertheless is required or will be required for the protection of the child.

(3) Routine cases. These cases involve all other child victims of abuse whose cases have not been designated as "threat-to-life" or"foster care".

7–4. CRC recommendations in spouse and child abuse cases

The CRC will make recommendations to commanders regarding treatment plans, inform commanders of progress, and solicit assistance from commanders to initiate recommended personnel actions when it is necessary to stabilize the soldier's assignment, or affect the soldier's reassignment for treatment or protective purposes in spouse or child abuse cases.

7–5. Transfer of CRC files

The losing CRC will send a copy of all CRC files to the gaining CRC prior to the arrival of the family according to the following procedures.

a. The losing CRC will make telephonic contact with and submit a written follow-up letter (including case summary) to the gaining CRC alerting the gaining team that a case is to be transferred and attaching a copy of the PCS orders or curtailment of tour orders, if applicable. A sample format is at figure 7-1. This letter will be sent to the gaining CRC as soon as the losing CRC is aware of the victim's location and PCS date. Whenever possible(e.g., OCONUS intra-theater or within CONUS transfers), the case manager at the losing CRC will telephone the gaining CRC, and notify a social worker of the anticipated transfer.

b. The gaining CRC will comply with the instructions in the transfer letter. The gaining CRC will complete the enclosure to the transfer of the CRC file letter and return it to the losing CRC within one duty day. A sample format for the enclosure is at figure 7-2.

c. On receipt of the reply from the gaining CRC, the losing CRC will mail the CRC file by certified mail, attaching a Postal Service PS Form 3811(Postal Services Return Receipt). This form may be obtained from any Post Office. The losing CRC will retain a copy of the file according to local procedures.

d. The gaining CRC will complete the PS Form 3811 acknowledging control of the file and mail the card. These three items (a copy of the transfer CRC file letter, the return letter from the gaining CRC, and the PS Form 3811)will document a successful transfer.

e. On the departure of the victim, the losing CRC will complete and submit a DD Form 2486 for the Army Central Registry to transfer an open case to another installation. A copy of the DD Form 2486 must be included in the case file.

f. Once face-to-face contact with the victim is established at the new installation, the gaining CRC will notify the losing CRC and complete and submit another DD Form 2486 per special instructions for transferring an open case.

g. When routine cases are transferred to Europe, the transfer letter will be sent to the Social Work Service Consultant, Landsthul Medical Center, APO AE 09180–3460. The Social Work Consultant will—

(1) Ascertain the final assignment of the soldier.

(2) Determine the servicing MTF based on the need for services and alert the gaining CRC of the pending transfer.

(3) Return the enclosure to the losing MTF so that the losing MTF may send the case record to the gaining MTF.

h. Transfer responsibility is complete when the transfer letter is acknowledged (telephonic acknowledgement is acceptable) by the losing CRC.All telephonic contacts must be recorded in the case file listing the name of the individual receiving the acknowledgment.

7–6. Judicial Authorization for Foster Care

When the CRC determines that child abuse is substantiated, and foster care is required, placement will be accomplished whenever feasible through the judicial system of the state or host-nation having jurisdiction over the child. In the United States, judicial authorization will be sought by the gaining CRC through coordination with the local CPS even in cases where the parents of the child have consented to foster care placement. In foreign countries, the judicial system of the host-nation court having jurisdiction over the child will be utilized to place a child in foster care in appropriate cases following coordination with the servicing SJA. In situations where judicial authorization cannot be obtained and emergency action is required to protect the life of an abused child, consult the SJA for guidance on the procedures to be followed. (See paras 3-23 and 3-25b(5)(b) for guidance and emergency procedures available.)

7–7. Transfer from the United States to foreign countries

a. Due to limited medical and social service support in foreign countries, a soldier stationed in the United States will not be reassigned to a foreign country on an accompanied tour in a CRC designated threat-to-life or foster care case until after coordination between CPS and the court having jurisdiction over the case, and one of the following occurs—

(1) The commander has determined, following a review of the recommendations of the CRC, that, although the child is in the soldier's custody, the risk of further abuse is substantially reduced. In such cases, the losing CRC will notify the gaining CRC about the case.

(2) A placement of the child with a family in the United States has been accomplished through the courts and the child will not accompany the abusive parent to the foreign-duty assignment.

b. In all other CRC designated threat-to-life and foster care cases, a reassignment, deletion or deferment request, as appropriate, should be forwarded to HQDA (TAPC–EPA–C), Alexandria, VA 22331 with a copy furnished to HQDA (ATTN: CFSC–FSA, Alexandria, VA 22331–0521).If the soldier does not initiate a request for deletion/deferment or reassignment, the commander may initiate a personnel action for the good of the command and the family. The procedures outlined in DA Pam 600–8–10 and DA Pam 600–8 will be followed. (See AR 614–20, para 3-5b(l)(e) for authority to delete soldiers from reassignment in child abuse cases, and para 3-5b(2)(e) for authority to defer soldiers from reassignment in domestic hardship cases).

7–8. Transfer within the United States

The reassignment of a soldier within the United States who has a

child in foster care because of child abuse should be coordinated with PERSCOM through the PSC, the losing and gaining CRC, and the CPS and courts losing and acquiring jurisdiction in the case. Deletion or deferment should be considered in cases where the CRC recommends against reassignment, or where reassignment will interfere with ongoing treatment. See paragraph 7-7b above for the procedures to be followed in deleting and deferring soldiers from reassignment.

7–9. Transfers from foreign countries to the United States

a. General. The procedures in this paragraph apply to the transfer of threat-to-life cases and foster care cases from foreign countries to the United States.

b. Threat-to-life cases.

(1) The chairperson of the losing CRC will alert the appropriate MACOM, contact the HQDA FAP POC (ATTN: CFSC–FSA), Alexandria, VA 22331–0521, DSN 221–9390), and promptly send the information and documents outlined in (a) through (c) below to the HQDA FAP POC by the most expeditious means possible, including express mail, according to AR 340–3, if necessary. The following documentation is required in order to transfer a threat-to-life case—

(a) Cover letter from the CRC chairperson containing—

1. Identification and assignment data on the soldier including SSN and MOS. (If PCS orders have been issued, a copy of the orders and amending orders should be attached to the letter for HQDA use, and, if available, a copy of curtailment of tour paperwork. Requests for reassignment, deletion, or deferment, as appropriate, will be made through HQDA PERSCOM according to the procedures outlined in paragraph 7-7b.

2. Identifying information on the victim and offender, a description of the type of abuse that occurred, and the CRC case determination as required by paragraph 7-3b.

3. Current status of the case, including pending criminal charges and likely disposition (e.g., court-martial, administrative discharge, civilian criminal charges).

4. CRC recommendations for placement of the child and treatment of the family, including (if applicable) the factual basis for the conclusion that the child is at risk of death or serious injury if custody is returned to or retained by the family.

5. Transfer plan and recommended treatment plan.

6. CRC prognosis regarding the feasibility of returning the abused child to the parents if the child has been placed in foster care in the foreign country.

7. The results of the case transfer conference, including the stated wishes of the parents regarding foster care, and their plans as to where and with whom the abused child will live during or enroute to the soldier's new duty assignment.

(b) Complete copies of CRC records; including all items indicated in paragraph 6-3b (except x-rays); a copy of the record of the Article 32, UCMJ hearing, if any; CID/MP reports of investigation; copies, if any, of the host-nation court orders and certified translations; results of the Army Central Registry background check; copies of all DD Form 2486 transactions.

(c) A one-page summary providing specific case background data(e.g., history of abuse, past treatment, and other services).

(2) HQDA FAP POC —

(a) Coordinates with PERSCOM to determine assignment locations where there are valid requirements for the soldier's grade and MOS, and with the Army Medical Command to locate services that meet family members' special medical and treatment needs.

(b) Contacts the chairperson of the CRC at the selected installation to determine whether or not civilian courts and installations are willing and able to exercise jurisdiction in such cases and to provide required services.

(c) Confirms the assignment which meets the total family need with PERSCOM, and requests a date for reassignment in order to allow required coordination to be completed prior to the departure of the child and family.PERSCOM will forward assignment instructions as required to the gaining and losing commands. HQDA will notify the gaining MACOM.

(d) Advises the CPS in the geographic location of the abused child's anticipated future residence (if long duration and different from the general location of the soldier's next assignment) and provides such information and records that will allow continuation of foster care or other protective services.

(e) Contacts the Interstate Compact Project POC as appropriate to facilitate the transfer when involving state agencies.

(f) Coordinates with CPS in the civilian jurisdiction to which the child is being taken in all cases where there is no Army installation nearby.

(3) The gaining CRC in the United States will—

(a) Assign a case manager to present all available case information to the local CPS.

(b) Notify the losing CRC when all necessary arrangements for the child's placement have been initiated.

(c) Request, in appropriate cases, the SJA at the gaining installation to appoint legal counsel to represent the abused child.

(d) In coordination with the SJA of the gaining CONUS installation and the local CPS, present the case records to the local court having jurisdiction over such cases when the child and the records arrive at the gaining CONUS installation. (See para 3-33g for procedures to be followed.)

(4) In cases where competent medical authority(DODD 4515.13–R, para 11-28) attests to the medical need to aeromedically transport the abused child to the United States, or other arrangements have been made to bring the child directly to the gaining installation in the United States, a member of the CRC of the losing command familiar with the case will accompany the child, whenever feasible, to the MTF of the gaining installation in the United States. The CRC member or designated unit representative accompanying the child will hand carry all records and information referenced in paragraph 7-9b. The abusive parent ordinarily will not accompany the victim. Upon arrival, the child will be taken to the MTF and admitted until placement in foster care or other protective arrangements are possible. The gaining CRC will coordinate these arrangements in advance of the child's arrival in order to expedite the child's placement. The child should be examined by a physician before placement.

(5) On the departure of the victim, the losing CRC will complete and submit a DD Form 2486 for the Army Central Registry to transfer an open case to the gaining installation.

(6) When the victim arrives at the new installation, the gaining CRC will complete and submit another DD Form 2486 according to special instructions for transferring an open case.

(7) In cases where the abused child, for whatever reason, will not be sent to the gaining installation in the United States, or the arrival of the child will be delayed, a CRC member from the losing command will not berequired to hand carry the records to the gaining installation in the United States if mailing the records will suffice. In all such cases, the chairperson of the losing CRC will coordinate the measures taken to ensure continued protection of the child with the HQDA FAP POC. In all cases where an escort accompanies the child, the records will be hand carried and delivered to a CRC member or the CPS case worker, as appropriate.

(8) An appropriate court order and/or parental consent for medical care and transportation of the child will be obtained by the losing CRC in any case in which the child is being transported to the United States in the custody of someone other than a parent. (See sample format at fig 7-3.)

c. Foster care cases. The transfer of foster care cases will not be coordinated with HQDA.

(1) The chairperson of the losing CRC will—

(a) Provide the documentation listed in subparagraphs (a), (b), (c)and (d) of paragraph 7-9b(1) to the chairperson of the gaining CRC.

(b) Notify the CRC chairperson at the gaining installation that a

foster care case is being transferred and provide additional information and documentation necessary for the initiation or continuation of foster care.

(c) Arrange and coordinate the transportation of the abused child and escort, if appropriate. (See para 7-9b(4) for the procedures to be followed.)

(d) Mail the records to the gaining installation in the United States prior to the arrival of the child except for cases in which the records are hand carried and delivered to a CRC member, or the CPS case worker, as appropriate (i.e. where an escort accompanies the child).

(e) On the departure of the victim, the losing CRC will complete and submit a DD Form 2486 for the Army Central Registry to transfer an open case to the gaining installation.

(f) Obtain, in any case in which the child is being transported to the United States in the custody of someone other than a parent, an appropriate court order and/or parental consent for medical care and transportation of the child.

(2) The chairperson of the gaining CRC—

(a) Coordinates with the CPS in the geographic location of the abused child's anticipated future residence and provides information received from the losing CRC that will help in planning for the initiation or continuation of foster care.

(b) Assigns a case manager to present all available case information to the local CPS prior to the victim's arrival at the gaining installation.

(c) Notifies the losing CRC when all necessary arrangements for the child's placement have been initiated.

(d) Completes and submits another DD Form 2486 according to special instructions for transferring in an open case when the victim arrives at the anticipated future residence.

(OFFICE SYMBOL)

MEMORANDUM FOR: Chairperson, CRC (At Gaining CRC)

SUBJECT: Transfer of Family Advocacy Program Case and Record.

1. Pursuant to AR 608-18, Army Family Advocacy Program, you are advised that ***(name, rank, SSN)*** has been reassigned to your area of responsibility for treatment and follow-up for ***(substantiated or suspected)*** (specify type of abuse or neglect of child or spouse).

2. ***(name, rank)*** has been assigned to ***(unit name and address on or about (date)***. A copy of the soldier's orders are attached.

3. It is the opinion of the CRC that further treatment is warranted.

4. Request the enclosed form letter be completed and returned to this office by electronic transmission within one duty day.

5. Point of contact is ***(name, rank, telephone number).***

Encl

(return letter from
the gaining CRC)

(Signature block)
Chairperson, CRC

Figure 7-1. Sample of losing CRC request for transfer of FAP case

(OFFICE SYMBOL)

MEMORANDUM FOR: Chairperson, ***(Losing CRC, MTF)***

We have received your case transfer letter and request that you forward the case file to the following address

USA MEDDAC
Social Work Service,
Fort Belvoir, Virginia 22060

Figure 7-2. Sample of gaining CRC reply to request for transfer of FAP case and file—Continued

(or)

We have received your letter of case transfer and currently are unable to locate the subject in question. Please advise further if necessary.

(Signature block)

Figure 7-2. Sample of gaining CRC reply to request for transfer of FAP case and file

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I, the parent/legal guardian of ***(name of child)***, a child of ***(age)*** years of age, hereby authorize***(name) (state description of person transporting child, e.g., a social worker, nurse),*** who is assigned to ***(agency of office)***, to transport the child on commercial or military aircraft and appropriate means of ground transportation, on or about, ***(date)*** to the medical treatment facility at Fort ***(installation)***, by the most direct route, for the purpose of allowing continued medical care and treatment.

I realize that my child may unexpectedly incur some other illness or sustain an injury either during travel or while at the medical facilities.

Because I am unable to accompany my child, I authorize and give my consent to all attending medical personnel within the system and facilities referred to above to treat and care for my child including all reasonable care needed for that condition or complication of it.

This authorization covers any emergency condition that involves the life or death of my child, as well as any non-emergency condition. If my child resists medical attention instructions, I give my consent to all medical personnel to use any reasonable discipline that a licensed physician considers necessary.

I also give my permission to place my child on any Department of Defense-owned or controlled aircraft or other vehicle so that he or she can be transported to or from a medical facility.

SGT William Jones***(Typed name of parent/guardian)*** (696) 341-1357***(Homephone)*** (202) 325-9390***(Office phone)***

(Signature of parent/guardian) (Date)

Michael Wilson, MD ***(Typed name of witness)***

2510 Stovall St., ALEX VA ***(Address of witness)***

(Signature of witness) ***(Date)***

Figure 7-3. Sample consent for medical care and transportation in non-aeromedical evacuation of family advocacy program cases

Chapter 8
Out-of-Home Cases in Department of Defense

Section I
Prevention of Out of Home Abuse

8–1. General
DA policy is to provide a safe and secure environment for all Army personnel and their families, prevent out-of-home child abuse, promote early identification and intervention in allegations of out-of-home child abuse in DoD operated or sanctioned activities (e.g., Child Development centers, Family Child Care homes, School Age/ Latch Key programs, Youth Services, DODDS, DDESS, Chaplain's programs, Boy and Girl Scouts and MWR programs).

8–2. Prevention of child abuse in out-of-home settings
a. Child abuse may occur in out-of-home settings despite an effective child abuse prevention program. Occurrences of abuse adversely affect the children, the parents, the organizational staff and damage the public image of the Army.

b. Army installation activities (e.g., CDS, YS)that supervise or sponsor activities in which children are involved will—

(1) Screen staff and volunteers according to applicable law, regulations, and organizational policies. The Army Central Registry will assist in providing background checks for volunteers, applicants and employees in CDS and YS programs and ACS family advocacy programs. The CRC chairperson and CDS, YS and ACS Director will develop local procedures for requesting and receiving this information.

(2) Provide adequate supervision of staff and volunteers.

(3) Encourage parents to observe and contribute to the activity's program.

(4) Provide safety education programs for children to the extent that local resources are available.

(5) Train staff and volunteers on behavioral and physical indicators of abuse and abuse reporting procedures.

(6) Observe children for evidence of child abuse or neglect.

(7) Prepare a child abuse SOP for coordination with the FAPM. SOPs will include procedures taken to prevent and respond to child abuse situations and address the following topics—

(a) Child supervision

(b) Discipline/touch policy

(c) Facility security (if applicable)

(d) Child abuse training

(e) Internal reporting and child abuse identification

1. Familial abuse

2. Abuse within DoD operated or sanctioned activity

(8) Develop employee, volunteer and parent handbooks that contain information on child abuse identification and reporting, and acceptable discipline policies.

(9) Encourage DoD operated or sanctioned activities to establish resource libraries containing training and educational materials on child abuse and neglect that is appropriate for employees.

8–3. Training
a. All persons working in DoD operated or sanctioned activities will receive written and verbal guidance from FAPM and/or CDS/ YS staff on the following topics within the first six months of employment, prior to FCC certification, or as part of volunteer orientation sessions.

(1) Internal reporting procedures.

(2) Legal requirements on reporting child abuse.

(3) Policies on discipline and use of corporal punishment.

(4) Identification of behavioral and physical indicators of abuse.

(5) Parent access policy.

(6) Touch policy.

(7) Field trip procedures.

(8) SOPs designed to minimize the risk of child abuse occurring in a DoD operated or sanctioned activity.

b. All persons working in DoD operated or sanctioned activities will receive training from FAPM on avoiding the appearance of abuse and protecting themselves from unwarranted accusations of abuse.

c. An update of subjects above will be included as part of ongoing annual in service training requirements.

d. The director of a DoD operated or sanctioned activity is responsible for planning and organizing all training. Training in identification and reporting will be coordinated with the FAPM. The FAPM will assist in providing the training and serve as a resource person.

8–4. Child Abuse Safety Education
Child abuse safety education programs will be set up for children ages 6-16 years in CDS/YS settings and in schools operated on Army controlled property(see paragraph 3-2f).

a. The FAPM is responsible for the overall child abuse safety education program on the installation and must keep a record of all training indicating the age group addressed, date, and number in the group.

b. Activity directors will coordinate all child abuse safety efforts with the FAPM to ensure that the staff is aware of reporting procedures.

c. All child abuse safety education programs will be developmentally appropriate for the age group. Activity managers will notify parents in writing in advance of all child abuse safety education programs.

8–5. Background Screening Requirements
a. FAPMs will assist DoD sanctioned activity directors develop records screening procedures to be used in hiring employees, obtaining persons who provide gratuitous services (PPGs), volunteers and certifying Family Child Care providers.

b. Background checks are required by DoD Instruction 1402.5 for all civilian providers involved in child care services having regular contact with children. The categories of providers include individuals hired with APF and NAF for education, treatment, health care, child care or youth services; employed under contract; and summer hires involved in the provision of child care services. Background checks for these employees include a set of fingerprints taken by law enforcement personnel designated by the Provost Marshal's office and processed through the FBI-ID and state criminal history repositories in each state where the individual has resided five year prior to hire. A National Agency Check (NAC) and National Agency Inquiry (NACI)through the Civilian Personnel Office (CPO) will be completed for government employees prior to hiring unless the hiring activity can provide line-of-sight supervision pending completion of checks. In addition, these individuals are subject to installation records check requirements pursuant to AR 608–10. Employees and new applicants will sign a statement of understanding acknowledging management's intent to conduct checks (DA Form 7214–R or DA Form 7214–R–E) and a release/consent form authorizing the employer to obtain information from the SCHR(DA Form 7215–R or DA Form 7215–R–E).

c. Installation Records Checks (IRC) are required for FCC providers, family advocacy program, foster care and respite care providers and specified volunteer positions. The IRC, at a minimum, should include checks conducted by the following— military police, Drug and Alcohol Program, Army Central Registry, Defense Clearance and Investigation Index (DCII), local civilian police and any other records checks as appropriate. Local nationals are subject to host government laws, the DCII, and the FBI-ID checks.

(1) Record screening procedures involve a review of available law enforcement and other records for any prior instances of substance abuse or relevant misconduct. The hiring, recruiting, or certifying official will develop procedures for requesting and receiving this information. When the application is for FCC certification, background record checks of all family members over the age of twelve living in the household will be completed.The availability of certain records depends on the governmental nature of the hiring or recruiting activity and the position being filled.

(2) The Army Central Registry check will be obtained through the CRC chairperson or FAPM as established by installation procedures.

(3) Local military and civilian law enforcement records check will be obtained through the PM and should include a check of the Defense Investigative Index (DCII).

(4) USACIDC Records Check will be obtained through the local Investigative Unit.

(5) The Alcohol and Drug Abuse checks will be obtained through the installation Alcohol and Drug Abuse Prevention Program.

d. Appropriate activity directors should, at a minimum, follow these procedures—

(1) Personally review all applications for accuracy of information(e.g., overlapping dates of previous employment).

(2) Interview applicant.

(3) Telephonically check all former employers listed for the past three years and verify the following—

(a) Employment dates.

(b) Reasons for leaving.

(c) Determine general work aptitude and habits.

(d) Clarify any concerns noted in the preemployment interview.

(e) Clarify any concerns about employment reassignments.

e. Take appropriate action pursuant to applicable provisions of AR 215–3, AR 608–10 and this regulation when record or applicant screening reveals instances of misconduct involving children, a history of threatening behavior (verbal or physical), substance abuse, or related misconduct. Consult the Staff Judge Advocate for legal guidance when needed.

f. Telephonically check personal references.

g. No waivers to background checks will be granted for center based or family child care program applicants, nor will they be provisionally certified before all checks are completed and evaluated unless the activity can provide line-of-sight supervision in accordance with DODI 1402.5.

8–6. Persons providing voluntary service in child care services

Although volunteers play an important role in all programs, they will not be allowed access to children before completion of proper screening and training. (See AR 215–1 on the acceptance of voluntary services in MWR activities.)Activity managers will—

a. Have each volunteer complete an application form to include information about the volunteer's arrest and conviction record and a signed waiver authorizing background checks as required above.

b. Assess the volunteer's attitude about discipline or abuse.

c. Evaluate the volunteer's education and work experience directly or indirectly related to children.

d. Conduct a preservice interview.

e. Assign new volunteers to an experienced/screened supervisor within the DoD operated or sanctioned activity.

f. Ensure that all regularly scheduled volunteers working directly with children attend a 2-hour training session that includes the program's disciplinary policy, child abuse identification and reporting procedures, and overall program policies.

g. Telephonically check at least two references provided by each volunteer. Deny the application if the volunteer fails to provide references.

h. Provide each volunteer with a program policy handbook and a written job description. Ensure all volunteers sign a policy statement acknowledging their awareness of the program's policies. Such policy statements will be identical to that signed by activity employees.

Section II
Reporting of out-of-home child abuse

8–7. Report Point of Contact

a. All allegations of child abuse in a DoD operated or sanctioned activity will be reported to the Report Point of Contact (RPOC) and appropriate law enforcement agency.

b. Installation reporting procedures and the RPOC phone number will be posted in each DoD sanctioned activity. The DoD hotline number must also be prominently displayed in the activity.

c. Each activity Director will develop internal reporting procedures for all suspected instances of child abuse or infractions of rules relating to the care of children.

8–8. Evaluation of allegation

The RPOC will notify the Military Police, the FAPM, and CRC chairperson of every allegation of child abuse as soon as he or she receives the report.The CRC chairperson will work cooperatively with the law enforcement agency to promptly assess reports of abuse and consult with personnel in the activity involved, the FAPM, and the supporting SJA, as appropriate.

8–9. DA Reportable and Non Reportable Child Abuse

a. DA reportable child abuse is child abuse that occurs in a DoD sanctioned or operated activity that includes any of the following—

(1) Any child sexual abuse regardless of whether injury occurs.

(2) Any child abuse resulting in the death of or major physical injury to the child.

(3) Any child abuse involving the deprivation of necessities that is determined to be widespread, chronic, or potentially life threatening.

b. Regulatory violations not constituting child abuse.If the allegation is not specifically related to child abuse, but merely alleges an infraction of a regulatory standard (such as a prohibition regarding corporal punishment), the CRC Chairperson will make a written record of the information and send it to the director of the appropriate DoD sanctioned or operated activity. Unless the infraction constitutes child abuse, it will neither be referred to the full CRC for consideration nor reported to the Army Central Registry. The activity director will take appropriate disciplinary action where necessary to resolve allegations that are considered policy violations. The activity director will submit a plan of corrective or disciplinary actions to the CRC.

c. Listed below are the responsible supervisory officials in various child care and child-oriented activities—

(1) Army Certified Foster Homes (OCONUS) or Respite Care Providers—Family Advocacy Program manager

(2) Child Development Centers—CDS Coordinator

(3) Family Child Care (FCC) Provider Homes—CDS Coordinator

(4) CDS Supplemental Programs and Services—CDS Coordinator

(5) School Age/Latch Key Program—CDS Coordinator or YS Director

(6) Youth Services—YS Director

(7) Chaplain Activities—Chaplain

(8) DoDDS/DoDESS—Principal

(9) Other DoD/Army sanctioned activities—Program Director

8–10. Initial Reporting Procedures

The installation FAPM will be notified of all abuse allegations (as identified in paragraph 8-9a) and will be provided a copy of the SIR or SSI pursuant to AR 190–40, paragraph 1-4c(21) (to facilitate reporting requirements to higher levels of command). Procedures established for reporting DA reportable child abuse are in addition to and do not supersede requirements outlined in AR 190–40. The FAPM will follow the procedures below for notifying the MACOM and HQDA Family Advocacy Program Manager.

a. Telephonic reports— Within 48 hours of receiving a report of abuse in a DoD operated or sanctioned activity, the installation FAPM will telephonically provide necessary information to the MACOM and HQDA FAPM and complete DA Form 7318–R (Initial Report of Child Abuse in DOD Operated or Sanctioned Activities). A copy of DA Form 7318–R is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper.

b. All reports will be mailed through the MACOM to HQDA, CFSC–FSA, ATTN: Family Advocacy Program Manager, 2461 Eisenhower Ave., Alexandria, VA 22331 within 5 working days

following the initial telephonic report.CFSC–FSA will distribute the reports to appropriate HQDA program managers and DoD as appropriate.

c. Follow-up/interim reports— The FAPM will make follow-up reports using DA Form 7318–1–R (Follow-up/Interim Report of Child Abuse in DOD Operated or Sanctioned Activities). A copy of DA Form 7318–1–R is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper.

(1) When significant changes in the status of the case occur, e.g., the arrest of a suspect, dismissal of pending criminal charges, firing of an employee.

(2) When required by MACOM or HQDA.

(3) When significant changes develop resulting in increased community sensitivity (e.g., a victim is suspected of being exposed to a sexually transmittable disease).

d. Close-out reports— A closeout report (DA Form 7318–2–R) is required after all investigations (e.g., command initiated investigations, police, grand jury) have been completed. The submission of a closeout report need not be delayed until the submission of a final law enforcement report or the completion of related briefs or appellate review. FAPM shall complete DA Form 7318–2–R (Closeout Reports of Child Abuse in DOD Operated or Sanctioned Activities). A copy of DA Form 7318–2–R is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper. The closeout report will include if applicable, a copy of an approved waiver relieving a Child Development Center or a Center based setting from the requirement for two employees being present in all child care areas during hours of operation.

Section III
Intervention

8–11. Investigation of out-of-home child abuse cases

The procedures for coordinating the investigation of child abuse cases on the installation, including those alleged to have occurred in DoD operated or sanctioned activities, will be addressed in an internal installation MOA.(See para 2-14.) Installations must work promptly and effectively to protect the victim(s), minimize further trauma and initiate the investigative process. Army policy further encourages joint interviews of victims by law enforcement personnel and social workers to minimize trauma. Initial handling of the investigation often proves critical to later efforts to prosecute suspected offenders.

a. When the responsible law enforcement agency and/or CRC receives a report of child abuse that has occurred in a DoD operated or sanctioned activity, the FAPM will notify the installation commander responsible for the DoD operated or sanctioned activity concerned.

b. The CRC, when appropriate, will assist in the investigation and will—

(1) Check with Army Central Registry for prior reports on any suspected offender.

(2) Include any suspected offender on a child/spouse abuse incident report, DD Form 2486 to the Army Central Registry.

c. The Activity Director will—

(1) Provide access to administrative files, attendance sheets, work schedules, client lists (e.g., parents, children, addresses and phone numbers) to investigators and other Army personnel who have an official need to know.

(2) Provide access to staff for investigative interviews.

(3) Take notes, observe facts, be alert to signs and symptoms of abuse in children in order to aid in fact collection during the investigative process, (e.g., keep a daily staff journal).

(4) Provide information approved by the strategy team to PAO or parents(see para 8-12).

d. When another Federal, state or foreign law enforcement agency assumes primary responsibility for the investigation, CID will work jointly with that agency whenever possible and will—

(1) Locate potential victims who have transferred from the local area using information provided by the FAPM, Activity Director and supporting CPO.Leads will be forwarded to the CID unit nearest the victims' new address with a request that the potential victim and his/her parents be interviewed in regard to the investigation.

(2) Coordinate with and request assistance from local CRC Chairperson and FAPM and, if appropriate, medical personnel prior to interviewing potential victims and their parents.

e. Other actions relating to management of the allegation.

(1) Employees suspected of abuse will be reassigned to duties with no contact with children, placed on administrative leave, or suspended pending completion of the investigation. Volunteers will be reassigned to duties with no contact with children or suspended pending completion of the investigation.

(2) Management personnel will maintain daily program operations as their first priority.

(3) Management personnel will assess the need for additional personnel to handle the added workload, if any.

(4) After careful assessment, Activity Directors will develop a staffing plan that ensures maximum safety of the children.

(5) The Activity Director will be available to talk with parents, keep a chronological log of events, and keep the staff informed (to the extent it is appropriate) of case development through staff meetings.

(6) FCC providers, foster care parents, and SPS programmers accused of abuse will be prohibited from providing child care for children (other than their own children or legal dependents) until such time that the allegation of child abuse is determined by the CRC to be unsubstantiated.

8–12. Strategy Team

An installation strategy team will be established to guide the installation's response to the allegation. The strategy team will work with local authorities as appropriate to determine if screening for multiple victims is necessary. The Strategy Team Chairperson, normally the DPCA or Chief of Staff, will report directly to the installation commander. The installation FAPM will serve as the action officer and subject matter expert in working with the strategy team. The FAPM will coordinate the overall installation response plan to include community awareness, information and services for parents and affected program staff.

a. A response plan must be developed to address the following issues—

(1) Corrective action or measures to be taken within the facility to ensure the safety of children (to include reassignment of the suspected offender pending completion of the investigation).

(2) Identification of a lead investigative agency/agent to coordinate interviewing, identify pool of potential victims, assign interviewing teams(social workers and criminal investigators), and develop matrix and offender profile as appropriate.

(3) The overall installation plan for communication with the press and public, services to victims and their parents, services for staff and staff rights. See Figure 8-1 for sample letter to parents.

(4) Appointment of a family liaison officer. In order to minimize rumors, designate an individual to serve as liaison for the families to keep families informed of how the investigation is proceeding and provide information on available resources. This person should not be closely involved in the case (e.g. FAPM, SWS, or affected activity personnel).Actions to support the family may include an information and referral support line to answer parents' concerns and refer them to professionals for screening, and parent support groups.

b. Members of the strategy team should include—

(1) DPCA or Chief of Staff, Chairman
(2) CID
(3) PAO
(4) CPO
(5) PM
(6) FAPM
(7) C, CRC/SWS

(8) Pediatrician
(9) SJA
(10) Program Activity Director (e.g., CDS, YS, etc)
(11) Civilian members of the team may include the FBI, US Attorney, or others as determined appropriate by the installation commander.

8–13. Medical evaluations.

a. Medical priorities are—
(1) Physical/mental well-being of the victim(s).
(2) Collection, documentation and control of medical/legal evidence in accordance with established MTF protocol utilizing the sexual assault examination kit, the child sexual abuse/neglect protocol, and photographs and laboratory work as necessary. Collection and documentation of evidence will be in conjunction with the investigative process.
(3) Follow-up care for patient(s)/victim(s) to include medical and psychological care, CRC referral, and support for the victim's family.

b. Medical responsibilities.Any service or department within the MTF receiving a child patient alleging sexual assault in a DoD operated or sanctioned activity will contact Chief, SWS and Chief, Pediatrics.
(1) Pediatrics will—
(a) Examine the child (victim)
(b) Care for the physical injury
(c) Document the injury. Collect evidence as indicated by the injury and/or directed by the investigating officer.
(d) Provide information to the investigating officer.
(e) Report findings to Chief, SWS (CRC).
(2) Social Work Service will—
(a) Respond to the notification by sending a staff member to the victim (and family) to provide assistance, chaperon service, and counseling.
(b) Notify CID.
(c) In conjunction with CID, interview the victim.
(d) Call an emergency CRC meeting as necessary.
(e) Provide short-term counseling for child (with family, as appropriate.)
(f) Assign a case manager(s).
(g) Meet with the installation strategy team if one has been formed.
(h) Schedule follow-up for case(s).
(i) Make referrals as needed (i.e., child psychiatry, private practitioners).
(j) Document cases.
(k) Prepare child for court, if applicable.
(l) Operate a 24-hour helpline to answer questions/screen potential victims.
(m) Be an ongoing resource.
(n) Provide staff support to reduce stress of activity staff. Request additional financial resources to support community referrals.

8–14. Treatment for the victim and family

a. Pediatrics will inform the family of the child's medical status and obtain SWS support for family.

b. SWS will—
(1) Ensure counseling services are provided.
(2) Coordinate with family liaison officer if appointed by installation strategy team.
(3) Provide support groups for families at times convenient for families.

8–15. Support for the staff of the activity in which abuse occurred

Support to organization staff is a joint FAPM/MTF responsibility.As appropriate, support groups will be provided for the staff of the organization in which child sexual abuse was alleged to have occurred.Support group services may be obtained from outside the military system through contracting (using CDS, FAP or COB resources) with local community resources or through the military system (PERSCOM call up of social work officers, utilization of Family Life Chaplains).

Section IV
Use of the DA Family Advocacy Regional Rapid Response Team and the DoD Family Advocacy Command Assistance Team (FACAT)

8–16. General

DA policy is to provide support to installations to assist in managing the initial investigations of child abuse cases that occur in a DoD operated or sanctioned activity, specifically in cases where local resources are not sufficient to adequately manage the investigation.

a. DA has established a multidisciplinary Regional Rapid Response team of specially trained social workers, criminal investigators, and pediatricians who can deploy to installations within 48 hours after notification.

b. DoD has established a similar multidisciplinary team, the FACAT, that is an additional resource available to DA installations in such cases. The DoD team is especially useful to ensure adequate and prompt investigation and to avoid the appearance of service coverup in highly sensitive cases. Team size may vary from five to seven individuals based on the needs of the installation, and deployments may range from seven to ten days.

8–17. Criteria for Team deployments

The DA Regional Response Team and the DoD FACAT prefer to deploy at the request of the installation commander (or designee) through MACOM and HQDA(CFSC–FSA). However, if the situation warrants, the Assistant Secretary of Defense (Personnel and Readiness) may deploy the DoD FACAT and the Assistant Secretary of the Army (Manpower and Reserve Affairs) may deploy the Army Regional Team without the installation commander's request.Criteria for deployment of either team include but are not limited to—

a. Multiple victims involved in an allegation of child sexual abuse.

b. Situations in which effective intervention as determined by the strategy team exceeds the installation's resources.

c. Circumstances in which potential for extensive adverse media coverage exists.

8–19. DoD Hotline Calls

The Military Child Care Act of 1990 requires that DoD establish and maintain a hotline for individuals to report suspected child abuse and safety violations in military child care programs (e.g., child development centers, family child care homes, and supplemental programs and services settings).The procedures outlined below apply only to DoD hotline calls. These procedures will be followed when calls are received by the OSD Office of Family Policy, Support and Services (OFPSS) alleging incidents of child abuse in child development settings—

a. OSD OFPSS will notify the Army Family Advocacy Program Manager.

b. The HQDA FAPM will disseminate the information to the appropriate MACOM telephonically within one working day of receipt of referral from OSD.

c. The MACOM FAPM will make telephonic notification to the installation FAPM and provide a telephonic report back to the HQDA FAPM within five days of the initial report and complete DA Form 7317–R (Child Abuse/Safety Violation Hotline Intake Information). A copy of DA Form 7317–R is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper.

d. HQDA FAPM must provide a telephonic report back to the OSD, OFPSS within seven days of the initial report. FAPM shall complete DA Form 7317–1–R (Child Abuse/Safety Violation Hotline 7-Day Follow-up Information). A copy of DA Form 7317–1–R

is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper.

e. A written status report (memorandum or message format) from the installation will be forwarded by the FAPM through the MACOM to HQDA, ATTN:CFSC–FSA, ALEX, VA 22331–0521, within 75 days of the initial report. All reports are subject to more frequent telephonic updates if deemed necessary by the OFPSS or CFSC–FSA.

f. If the case is not resolved upon the submission of DA Form 7317–1–R (Child Abuse/Safety Violation Hotline 90-Day Follow-up Information) FAPM will be required to submit DA Form 7317–2–R every 75 days thereafter until the case is closed. A copy of DA Form 7317–2–R is available at the back of this regulation for reproduction purposes. It will be reproduced locally on 8 1/2 by 11-inch paper. In the event circumstances require more frequent updates, reporting requirements will be addressed on a case-by-case basis.

SAMPLE LETTER TO PARENTS FROM THE COMMAND

Dear Sponsor:

The Commander has been apprised of incident (s) of alleged child sexual abuse reported to have occurred at the (activity). Immediately upon receipt of the report, proper law enforcement authorities were notified and concurrently the child was provided a thorough physical examination by physicians trained to handle cases of this nature. Thereupon, the child and the parents began a professional program of treatment to deal with the situation. Also on the day notification was received, the employee believed responsible was removed from his or her position and assigned duties with no contact with children.

Our records reflect that the employee implicated in this incident may have provided care to your child.

We have been in touch with health care professionals and experts in this area. Procedures have been developed to fully inform you of the facts and provide full services to your children. This process also permits professionals the opportunity to elicit relevant information concerning any possible inappropriate contact from any youngsters who might have been exposed to this suspect without further traumatizing the youngster involved.

We have established a Child Abuse Help Line at(555) 555-5555 for parents to call for answers to any questions they might have. The line is manned during regular duty hours by the Case Review Committee. An answering service is provided after duty hours so that parents can express their concerns and request a call back. Calls will be returned as soon as possible.

Our health care professionals have put together the enclosed check list of the most often exhibited symptoms of child abuse. In the event your child or children exhibit any of these symptoms, we request that you contact_____immediately. Please do not question your children or conduct any kind of investigation. We have arranged to have trained professionals, with your approval, interview your child. Improper questioning might well impede a child's ability to recall events, color his or her recollection and make it difficult if not impossible to get a true reading of what really did happen.

As a follow-up, we are committed to providing treatment, care and counseling for any of the patrons of the (activity) who may seek our assistance. We will, of course, continue working with law enforcement authorities to support any further actions that might be warranted.

Please call the Child Abuse Help line if you have any questions.

Signature
Director, Community Acitivities.

Figure 8-1. Sample memorandum to parents

Appendix A
References

Section I
Required Publications

AR 25–55
Department of Army Freedom of Information Program.

AR 340–21
The Army Privacy Program. (Cited in paras 6-2 and 6-4b. See also para 6-8a).

AR 608–1
Army Community Service Program. (Cited in para 3-26b(5)).

AR 608–10
Child Development Services. (Cited in para 8-5b).

DOD Directive 4515.13–R Jan 80
Air Transportation Eligibility. (Cited in para 7-9b.) (A copy may be obtained through the servicing medical treatment facility.)

DOD Directive 6400.1
Family Advocacy Program.(Cited in para 2-6.)

DOD Manual 6400.1–M
Family Advocacy Program Quality Assurance Standards.(Cited in para 1-6.)

DOD Instruction 6400.2
Child and Spouse Abuse Report. (Cited in para 5-1.)

DOD Instruction 6400.3
DOD Family Advocacy Command Assistance Team. (Cited in para 8-1.)

DOD Instruction 1402.5 Jan 1993
Criminal History Background Checks on Individuals in Child Care Services. (Cited in para 8-5h.)

Manual for Courts–Martial, United States, 1984
(Cited in para 4-1.) (A copy may be obtained through the servicing staff judge advocate office.)

Section II
Related Publications

A related publication is merely a source of additional information. The user does not have to read it to understand this publication.

AR 27–10
Military Justice

AR 40–66
Medical Record and Quality Assurance Administration

AR 190–30
Military Police Investigations

AR 190–40
Serious Incident Report

AR 195–2
Criminal Investigation Activities

AR 340–3
Official Mail Cost Control Program

AR 360–5
Army Public Affairs, Public Information

AR 600–37
Unfavorable Information

AR 600–85
Alcohol and Drug Abuse Prevention and Control Program

AR 601–280
Total Army Retention Program

AR 614–30
Oversea Service

AR 614–200
Selection of Enlisted Soldiers for Training and Assignment

AR 635–100
Officer Personnel

AR 635–200
Enlisted Personnel

DA PAM 600–8
Management and Administrative Procedures

DA PAM 600–8–10
Management and Administrative Procedures: Individual Assignment and Reassignment Procedures

Section III
Prescribed Forms

DA Form 7317–R
Child Abuse/Safety Hotline Intake Information. (Prescribed in para 8-19c.)

DA Form 7317–1–R
Child Abuse/Safety Violation Hotline 7-Day Follow-up Information. (Prescribed in para 8-19d.)

DA Form 7317–2–R
Child Abuse/Safety Violation Hotline 90-Day Follow-up Information.(Prescribed in para 8-19f.)

DA Form 7318–R
Initial Report of Child Abuse in DOD Operated or Sanctioned Activities.(Prescribed in para 8-10a.)

DA Form 7318–1–R
Follow-up/Interim Report of Child Abuse in DOD Operated or Sanctioned Activities. (Prescribed in para 8-10c.)

DA Form 7318–2–R
Closeout Reports of Child Abuse in DOD Operated or Sanctioned Activities. (Prescribed in para 8-10d.)

DD Form 2486
Child/Spouse Abuse Incident Report. (Prescribed in para 1-6c(11)(c) and para 2-4c.)

Section IV
Referenced Forms

DA Form 4841–R
Child Development Services (CDS) Program/Facility Report

DA Form 3444
Terminal Digit File for Treatment Record

DA Form 7215–R/DA Form 7215–R–E
Release/Consent Statement

SF 600
Health Record-Chronological Record of Medical Care

PS Form 3811
Postal Services Return Receipt

Appendix B
Guidelines

Section I
Standards of Care For Referral, Assessment, Determination and Treatment of Child Abuse

B–1. Referral
All reports of child abuse and neglect will be assessed.

B–2. Assessment
a. The following must be completed within 24 hours from receiving the report:

(1) The social worker will evaluate the victim using the child abuse risk evaluation guidelines. In sexual abuse cases, a joint evaluation will be conducted by the MTF social worker, CID, and Child Protective Services worker (in CONUS).

(2) A physician will review the victim's medical records and perform a medical evaluation.

(a) In physical and sexual abuse, the examining physician should consult with a pediatrician at the time of the examination.

(b) The attending physician will coordinate with Social Work Service prior to discharging or releasing the child.

(3) The MTF social worker will notify the alleged military offender's unit commander or civilian supervisory equivalent of the following:

(a) The incident.

(b) The protection plan.

(c) That Social Work Service will follow-up with the command to ensure compliance with the protection plan.

b. The following must be completed within 72 hours from receiving the report:

(1) The MTF social worker will contact the appropriate law enforcement agency who will provide a rights advisement to the suspected offender. The social worker will document in the family case file that the law enforcement agency was notified and that the rights advisement was conducted.

(2) The interviewing social worker will ensure that the suspected offender is advised of the evaluation process and limits of confidentiality.

(3) The MTF social worker will complete a parental/caretaker and family assessment.

c. The following will be completed within seven days from receiving the report:

(1) The MTF social worker will query the Central Registry for prior family advocacy reports.

(2) The MTF social worker will contact every collateral organization involved in the case (i.e., the police, school, child care center, community health nurse, etc) and obtain any pertinent information and documentation.

B–3. Determination
a. The CRC initial and review case presentations will be completed using a standardized case presentation format.

b. The unit commander or civilian supervisory equivalent will be invited to attend the case presentation of his/her soldier as a nonvoting member.

c. CRC case determination process:

(1) A majority vote is required to determine that the facts substantiate a case. The case determination will be recorded in the CRC minutes.

(2) A quorum (two-thirds) of the CRC members on orders must be present to vote on case determinations.

B–4. Treatment
a. The intervention format must be problem basedand goal oriented.

(1) Problem based - Each identified problem must be adequately defined.

(2) Goal oriented - Each element of the treatment plan must address an identified problem.

b. The intervention program will consist of four levels of service. To meet the standards of care the following services must be available:

(1) Level 1 - No additional services beyond the evaluation/initial intervention required (Client participation time frame is less than one week from receipt of report).

(2) Level 2 - Enrollment in the Domestic Violence Awareness Workshop (DVAW). See DVAW program outline. (Client participation time frame is 1-4 weeks).

(3) Level 3 - Enrollment in one or more of the following services(time frame is 5-24 weeks):

(a) Marriage counseling.

(b) Family therapy.

(c) Individual counseling.

(d) ADAPCP.

(e) Parenting (PET/STEP) classes.

(f) Stress management program.

(g) Violence Management counseling (refer to the Violence Management program outline).

(h) Financial planning.

(i) Foster care and respite care.

(4) Level 4 - Long term treatment of sexual abuse offenders(Client participation time frame is longer than 24 weeks).

c. The social worker will utilize the child abuse intervention guidelines to determine the specific intervention services needed.

Section II
Child Neglect Evaluation Guidelines
(This list is provided as a guide and is not all inclusive.)

B–1. Mild Child Neglect
a. Routine medical and dental exams not provided.

b. Immunizations are not provided or are delayed.

c. Treatment not sought for minor injuries or illnesses where treatment might facilitate faster recovery.

d. Conditions in home place child at risk of minor illness or superficial injury.

e. Lack of supervision places child at risk of minor injury.

f. Isolated incident or no repetitive pattern evident. No readily apparent physical or emotional harm to a child placed in a potentially harmful situation.

B–2. Moderate Child Neglect
a. Denying food for more than 2 consecutive meals.

b. Locking a child outside when inappropriately dressed or for periods of time which could result in harm or injury.

c. Treatment for illnesses/injuries are usually provided but almost always delayed, though not excessively.

d. Physical needs not met, child at risk of minor distress or discomfort.(Some essential clothing missing, children may be quite hungry, but no actual illness).

e. Lack of supervision which places the child at risk of serious harm or imminent danger.

f. Physical conditions in the home place child at risk of harm, but are unlikely to require medical treatment (unsanitary or unsafe living conditions).

g. Repeated incidents of neglectful behavior or child suffers physical or emotional harm from circumstances. Short term medical treatment (one time)may be indicated.

B–3. Severe Child Neglect

a. Driving a motor vehicle with a child passenger while intoxicated.

b. Failure to use child restraints in an automobile.

c. Locking a child in a closet for long periods of time.

d. Forcing a child outside in inclement weather for extended periods of time.

e. Care is not provided for a medical condition that could cause permanent disability if not treated. (injury, illness, suicidal threats or gestures)

f. Unreasonable delay in obtaining medical and dental services which endangers the child's life.

g. Failure to thrive diagnosis (absent medical basis, e.g. birth defect, disease, etc.)

h. Failure to give prescribed medication when such failure places child's health or functioning at risk.

i. Physical needs not met, serious illness or injury involved. (poor diet, clothing, or hygiene)

j. Lack of supervision that results in serious harm or injury.

k. Physical conditions in the home place child at risk of serious harm that would require medical treatment (e.g. exposed wiring, toxic materials within reach).

l. Parent describes exaggerated and/or falsified medical symptoms which result in unnecessary medical tests performed on the child.

m. Pattern of neglectful behavior resulting in hospitalization or alternate placement for the safety of the child.

Section III
Child Physical Abuse

B–1. Mild Child Physical Abuse

(This list is provided as a guide and is not all inclusive.)

a. Bruises on legs, arms, or buttocks, not requiring medical treatment and confined to one area.

b. Superficial welts, scratches or abrasions.

c. Hair pulling that does not remove hair.

d. Minor physical injury or no medical treatment indicated.

B–2. Moderate Child Physical Abuse

a. Minor burns, blisters, abrasions, confined to a small area on child's arm or leg.

b. Superficial injuries that are very widespread.

c. Small cut requiring stitches.

d. 2nd degree (moderately severe) burns.

e. Sprains, mild concussions, broken teeth.

f. Hair pulling that results in hair removal.

g. Minor or major physical injury; short term medical treatment(one visit) may be indicated.

B–3. Severe Child Physical Abuse

a. Extensive cuts requiring stitches.

b. Head injuries.

c. Internal Injuries.

d. 3rd degree burns to any area of the body.

e. Minor burns to an extensive area of the body.

f. Injuries resulting in impairment to sight, hearing or mental impairment.

g. Burns or bruises to the genital area.

h. Extensive and multiple bruises in various states of healing, indicating a pattern of abuse.

i. Cuts, bruises, abrasions on face, neck or shoulders.

j. Minor burns on face or abdomen.

k. Any use of torture such as electric shock or burning with objects.

l. Preventing a child from breathing for a short period of time.

m. Administering to a child any harmful substance or any substance that results in harm to the child.

n. Major physical injury requiring long term medical treatment, inpatient care, or alternate placement.

o. Death

Section IV
Child Sexual Abuse

B–1. Mild Child Sexual Abuse

(This list is provided as a guide and is not all inclusive.)

a. Slight sexual innuendos or provocative statements that are made to the child by a non-caretaker or caretaker.

b. No physical contact; no readily apparent physical or emotional harm to child, no medical or mental health treatment indicated.

B–2. Moderate Child Sexual Abuse

a. Parent makes no effort to prevent the child from observing sexual behavior of others.

b. Adult exposes him/herself to the child but ceases if child objects.

c. Caretaker has fondled the child or touched the breast or genital area for other than hygienic purposes.

d. Physical contact that does not involve oral, vaginal, or anal penetration or physical injury. Short term mental health or medical treatment (one time) may be indicated. Significant verbal or physical maltreatment may have been part of the experience.

B–3. Severe Child Sexual Abuse

a. Child has been engaged by an adult or older child in sexual intercourse, masturbation or oral genital sex.

b. Child has been engaged in physically dangerous or sadomasochist practices (even in the absence of intercourse).

c. Child has been forced by an adult to engage in sexual activity with a child of the same age or younger, or with an animal.

d. Contact involves oral, vaginal, anal penetration or physical injury.Long term mental health or ongoing medical treatment may be indicated.Severe verbal threats, physical, or emotional maltreatment may be present.

Section V
Child Abuse Safety Risk Assessment

B–1. Descrition of Injury

a. Severe physical and/or sexual abuse(Refer to the Child Abuse Evaluation Guidelines)

b. Evidence of repeated and/or frequent abuse

c. Re-abuse after initial report and intervention

d. Child less than 3 years old with physical abuse

B–2. Child Characteristics

a. Child behavior toward the parent that is unduly provocative or obnoxious.

b. Child extremely afraid to return home

c. Parental Characteristics:

(1) Current psychiatric dysfunction

(2) Substance abuse history

(3) Violent criminal history

(4) Parents persistently refuse intervention and treatment services

d. Multiple on-going crises to include:

(1) Chaotic/dysfunctional family

(2) Health problems

(3) Infidelity

(4) Separation/deployment/PCS/retirement

(5) Financial Problems

Note. The presence of any of the above increases the likelihood of re-injury.

Section VI
Guidelines For Standard of Care For Referral, Assessment, and Treatment of Spouse Abuse

B–1. Referral

All reports of spouse abuse will be assessed.

B–2. Assessment

a. The following must be completed within 24 hours from receiving the report:

(1) The social worker will evaluate the victim using the spouse abuse assessment guidelines. If the victim refuses to be seen, the social worker will document the attempt and the victim's refusal in the family advocacy case file.

(2) A physician will perform a medical examination on the victim. If the victim refuses a medical examination, the social worker will annotate the refusal in the family advocacy case file.

(3) A physician will review the victim's medical record for prior spouse abuse incidents.

(4) The social worker will notify the alleged perpetrator's commander or civilian equivalent supervisor of the following:

(a) The incident.

(b) The protection plan.

(c) That Social Work Service will follow-up with the command to ensure compliance with the protection plan.

b. The following must be completed within 72 hours from receiving the credible report:

(1) An assessment of psychological or physical harm of any children residing in the home.

(2) The social worker will assess the potential for reinjury using the spouse abuse risk assessment guidelines.

(3) The social worker will advise the abuse victim of his/her patient rights (i.e., available protection, location of shelters, and availability of legal advice).

(4) The social worker will query the Central Registry for prior substantiated cases of domestic violence.

c. The following must be completed within seven days from receiving the report:

(1) The social worker will query every collateral organization involved in the case (i.e., the military police) and obtain any pertinent information and documentation.

B–3. Determination

a. The CRC initial and review case presentations will use a standardized case presentation format.

b. The unit commander or civilian supervisory equivalent will be invited to attend the CRC case presentation of his/her soldier, as a non-voting member.

c. CRC case determination process:

(1) Characterizing a new case as"substantiated"requires a majority vote. The case determination (substantiated or unsubstantiated) will be recorded in the CRC minutes.

(2) A quorum (two-thirds) of the CRC members on orders must be present in order to make a determination.

B–4. Treatment

a. The intervention format must be problem based and goal oriented.

(1) Problem based—Each identified problem must be adequately defined.

(2) Goal oriented—Each element of the treatment plan must address an identified problem.

b. The intervention program will consist of three levels of service.These are minimal acceptable services for a spouse abuse treatment program.The services are as follow:

(1) Level 1—No additional services beyond the evaluation/initial intervention required (Client participation time frame is not to exceed one week from receipt of the report).

(2) Level 2—Enrollment in the Domestic Violence Awareness Class(Client participation time frame is 1-4 weeks).

(3) Level 3—Enrollment in one or more of the following services:Individual counseling, violence management groups, batterers group, stress management program, marriage counseling, family therapy, victim supportgroups, emergency housing, ADAPCP, and budget counseling (Client participation time frame is 5-36 weeks).

c. The spouse abuse intervention guidelines should be used to assist in determining the specific intervention services.

Section VII
Domestic Violence Awareness Workshops (DVAW)Outline

B–1. Introductions

a. Instructors: Background and experience.

b. Participants: Where from, current job, previous job, something you are good at doing, how you feel and what you think about being here; how did you learn about DVAW?

B–2. Information

a. SWS Programs—what we do and how.

b. Acronyms (CRC, DSS, ACS, DVAW, etc.).

c. Quiz on family violence.

d. Film on spouse abuse (Hot Heads of the House or alternate) and discussion.

B–3. Dynamics of Family Violence

a. Definition.

b. Types of abuse.

c. Facts and statistics (Child and Spouse).

d. Characteristics of an abuser (Child and Spouse).

e. Characteristics of a victim (Child and Spouse).

f. Cycle of violence (Spouse).

g. Perpetration of violence (Child); by whom, when how managed, effects, complicity.

h. Learned behavior; how, when, results.

i. Why women/men stay in an abusive relationship.

j. Time Out—Use and misuse.

k. Power and control issues.

l. Film of child abuse and discussion.

m. Effects of Battering on Children.

(1) Discipline v. Punishment.

(2) Alternate methods of discipline.

n. Review answers to quiz on family violence.

o. Resources:

(1) Installation—ACS, SWS, Chaplain Programs(give participant ACS Booklet) et).

(2) Community—Men's Center, Shelter.

B–4. What's next?

a. ACS

b. Couples'

c. Individual

d. Family Counseling

e. Questions

Section VIII
Violence Management—Program Outline (8 Sessions)

B–1. 1st Session

a. Types of Abuse

b. Time-Out

c. Feelings About Being Here

B–2. 2nd Session

a. How We Learn About Violence

b. Total Behavior Basic/Genetic Needs

c. Victim's Experience

d. Abuser's Experience

e. Battering Cycle of Abuse

f. Triggering Actions

B–3. 3rd Session

a. Power and Control Issues

b. Emotional Abuse

c. Intimidation

d. Isolation

e. Economic Issues

f. Emotional Abuse
g. Film

B–4. 4th Session
a. Power and Control Issues
b. Using Male Privilege
c. Threats
d. Children
e. Sexual Abuse
f. Cultural Values and Beliefs
g. Control Behavior -- Do Log

B–5. 5th Thru 8th Sessions Therapy Regarding Issues On:
a. Stress Management
b. Anger Control
c. Effective Communication Triggers
d. Anger Talk Up/Anger Talk Down

B–6. Handouts and Audiovisuals
a. Group Agreement
b. Confidentiality Statements
c. Time-Out Agreement
d. Types of Abuse (Definition)
e. Personality Test; Stress Test; Anger Log
f. Film
g. Anger/Scale Violence
h. Awareness Packet Behavior
i. Checklist Self-Evaluation
j. Control Behavior Log

Section VIIII
Spouse Abuse Assessment Guidelines
(This list is provided for use as a guide and is not all inclusive.)

B–1. Mild Spouse Abuse
a. Spouse verbally threatened
b. Mild physical injury or no medical treatment indicated.

B–2. Moderate Spouse Abusee
a. Something thrown at spouse
b. Spouse pushed, grabbed or shoved
c. Spouse slapped
d. Spouse kicked
e. Spouse kicked, bit or hit with a fist (once or twice)
f. Minor or major physical injury; short term medical treatment (one visit) may be indicated.

B–3. Severe Spouse Abuse
a. Any injury during pregnancy
b. Spouse choked or strangled
c. Spouse severely beaten (hit, kicked, etc., numerous times)
d. Spouse threatened with a knife or gun
e. Spouse cut with knife or shot at
f. Battered spouse syndrome (to include emotional abuse and intimidation)
g. Spouse threatened or hit with a motor vehicle
h. Spouse sexually abused
i. Major physical injury or long term medical treatment, inpatient care or move to alternate environment for the safety of the spouse.

B–4. Spouse Abuse Safety Risk Assessment
a. Lethality of injury (Refer to the Spouse Abuse Evaluation Guidelines)
b. History of injuries (progressive in severity and frequency)
c. Involvement of lethal weapons/objects
d. Occurrence during pregnancy
e. Significant substance abuse
f. Maintenance of rage after altercation
g. Perpetrator witnessed abuse in childhood
h. History of behavior involving verbal or physical threats toward non-family member
i. Threat of abandonment of abuser by victim
j. Unemployed abuser

Each case presentation must include the following:
1. Case #
2. Demographics: age, race, sex of victim and abuser
3. Presenting events (to include referral source)
4. History of prior abuse
5. Family dynamics
6. Precipitating stress factors
7. Agencies involved in assessment
8. Records checks - (include date of check)
   a. Central Registry
   b. Medical records
   c. Police records
9. Command notification date
10. Major contributing problem
11. Determination recommendation
   a. Case Presenter
   b. CRC
12. Treatment Plan Recommendation
   a. Case Presenter
   b. CRC
13. PCS/Movement Considerations
14. Date of initial review

Figure B-1. Family Advocacy Initial Case Presentation Format

1. Case # / case manager
2. Presenting events and CRC case determination (to include date of determination)
3. Present any clinically pertinent events (since initial case presentation)
4. Review of treatment plan accomplishments by problem and goal (include level of participation and professional assessment)
5. Recommendation for further action-options is
   a. Continue with current treatment plan
   b. Monitor
   c. Close case
   d. Revise treatment plan
6. Date of next review

Figure B-2. Family Advocacy Review Case Presentation Format

Appendix C
Memorandum of Agreement

This appendix is a sample format illustrating roles and responsibilities that could be negotiated and agreed upon between an Army installation in the United States and the adjoining community in responding to spouse and child abuse that occurs in military families.

1. Purpose. This agreement establishes written procedures to integrate the exercise of jurisdiction vested in (Simpson) County and Fort (Green)authorities in matters involving the abuse of children of military families.

2. General. This agreement does not purport to create additional jurisdiction nor to limit or modify the existing jurisdiction vested in the parties. This agreement supersedes all previous agreements between (Simpson)County juvenile authorities and Fort (Green) pertaining to child abuse and misconduct.

3. Authority. The State of (Kansas), through the (Simpson) County juvenile authorities, and under the authority granted by (12 Kansas statutes, section 2113), is responsible for the protection of abused children within (Simpson)County. The Commanding General, Fort (Green), by virtue of his inherent authority as commander, and through the specific authority granted to him under the Army Spouse and Child Abuse Program, Army Regulation 608-18, is responsible for the protection of abused children of military families within his command, as well as for maintaining law, order, and discipline on the installation. The Commanding General's authority to provide protection for children of military families is limited, however, by the lack of a federal judicial framework in which the status of children can be adjudicated and in which appropriate, judicially managed remedies can be mandated. Fort (Green)therefore, relies upon the (Simpson) County Juvenile Court to exercise its authority, where necessary, in cases of abused children of military families.The exercise of the Court's jurisdiction in cases of child abuse arising on the installation is supported by congressional deference to and reliance upon state child-related statutes (see e.g., The Child Abuse Prevention andTreatment Act, 42 U.S.C. 5101, The Education for All Handicapped Children Act of 1985, 20 U.S.C. 1412; and The Correction of Youthful Offenders Act, 18 U.S.C. 5001), and by developing case law which upholds the exercise of state civil jurisdiction within areas of exclusive federal legislative jurisdiction, where that exercise of state authority, as is contemplated by this agreement, will not undermine federal sovereignty.

4. Definitions. For the purpose of this agreement, the following definitions apply:

a. The (Simpson) County Juvenile Court, hereinafter referred to as the"Court," is the court empowered with original jurisdiction to adjudicate child abuse cases in (Simpson) County.

b. The (Simpson) County Department of Child Protective Services, hereinafter referred to as CPS, is the agency primarily responsible for the intake, investigation, and management of child abuse cases in (Simpson)County.

c. Social Work Service, hereinafter referred to as SWS, is the agency of the Fort (Green) Medical Treatment Facility, which is responsible on the intake investigation and management of on-post child abuse and certain military-related incidents and for collection of information pertaining to off-post child abuse.

d. The Family Advocacy Program, hereinafter referred to as the FAP, is an Army program established by Army Regulation designed to promote the growth, development and general welfare of children of Army families by coordinating human services provided to such children and by interceding on their behalf when necessary.

e. The Fort (Green) Case Review Committee, hereinafter referred to as the CRC, is a multidisciplinary team appointed and supervised by the MTF commander to handle cases of military children and families where the children have been, or are suspected to be, abused. The CRC will be the receiving agency for all on-post child abuse.

f. The Provost Marshal, hereinafter referred to as the PM, coordinates all law enforcement activity on Fort (Green), and is primarily responsible for investigating crimes involving child abuse on the installation. The PM coordinates such investigations with the U.S. Army Criminal Investigative Command, and federal and state law enforcement authorities, as appropriate.

g. The Provost Marshall serves as the report point-of-contact, hereinafter referred to as the RPOC, for Fort (Green) and receives all reports of child abuse occurring on or off post. The RPOC notifies all agencies required to be notified by regulation and this MOA.

h. Child Abuse includes child sexual abuse and child neglect, and means the physical or mental injury, sexual abuse or exploitation, negligent treatment, or maltreatment of a child under the age of eighteen, by a person(including any employee of a residential facility or any staff person providing out-of-home care) who is responsible for the child's welfare, under circumstances that indicate that the child's health or welfare is harmed or threatened thereby.

i. Off-post incident is an act of child abuse involving a military family that occurs beyond the boundaries of Fort (Green) and that the jurisdiction of (Simpson) County.

j. On-post incident is an act of child abuse involving a military family that occurs within the boundaries of Fort (Green) or that is referred to Fort (Green) from sources outside the jurisdiction of (Simpson) County.

k. Military-related incident is an act of child abuse within (Simpson)County not involving a child of a military family but nevertheless of interest to Fort (Green) authorities by virtue of the military status of the alleged abuser or of the occurrence of the incident within the boundaries of Fort (Green).

l. Child of a military family is a person under the age of 18 who is a natural or adopted child or step-child of any soldier.

5. Report and Notification Requirements. Every soldier and civilian member of the military Community should report information about known and suspected cases of child abuse to the RPOC or the appropriate military law enforcement agency. The RPOC or the appropriate law enforcement agency will notify CPS or other civilian authorities, as appropriate, of all on-post incidents of child abuse, in addition to notifying the appropriate authorities on-post as required by Army Regulation and agreement. CPS will notify the RPOC of all off-post incidents of child abuse.

6. Intake Procedures.

a. CPS and SWS share joint responsibility for the intake of information about child abuse. On-post incidents may initially be investigated by SWS, and law enforcement personnel. Where requested by post authorities, and upon approval by CPS, CPS social workers may assist in the investigation of on-post incidents. Prior to entering the installation for any investigation, the CPS investigator will notify the PM office and request assistance if required. Off-post incidents will be investigated by CPS with assistance by other civilian authorities, where appropriate. Where requested, and upon approval by post authorities, SWS social workers may assist in investigation of an off-post incident. Military-related incidents

Figure C-1. Sample format for a Memorandum of Agreement—Continued

occurring within the boundaries of the installation initially will be investigated by military authorities to determine the extent of military criminal and administrative interests involved, and thereafter will be reported to CPS or other civilian authorities, as appropriate.

b. All cases of suspected child abuse will be brought to the attention of SWS. When a report of child abuse is received, SWS will, upon assessment and necessary investigation, immediately report information about the cases to CPS. Similarly, CPS, upon receiving a report of child abuse involving the children of military families from sources other than SWS, will provide SWS the case information as expeditiously as possible.

c. Upon receipt of a report of an on-post incident, SWS will seek, in appropriate cases, authority for temporary protective custody through the Court. Upon a grant of authority by a juvenile judge, SWS will coordinate with CPS to place the child(ren), will arrange for the initiation of child protective proceedings, and will notify the parties and the Court of the hearing date and time.

d. All children who are removed from their homes on the installation for their own protection will be first examined at the MTF prior to being taken off the installation. Parental consent for a medical examination in such cases is not required.

7. Court Representation. Presentation of cases to the Court is the responsibility of CPS working with the County Attorney.A representative of the CRC, however, will be made available in appropriate cases to assist in the preparation and presentation of cases before the court.

8. Treatment Programs.

a. It is the policy of all parties to this agreement that within budgeting, personnel and regulatory constraints, all available medical and social assets for use in treatment programs will be used. In all cases involving the abuse of children of military families, any assets of Fort(Green) which are available for use for aid in treatment may be integrated into CPS or court-mandated treatment plans. Availability of assets will be determined by the CRC, with concurrence of the MTF commander or the Fort(Green) commander, where necessary.

b. CPS shall exercise primary responsibility for the development and implementation of treatment programs for all off-post and military-related cases and for all on-post cases in which there has been court involvement.SWS shall exercise primary responsibility for all other on-post cases on a case-by-case basis. Oversight authority for all or portions of a treatment program may be delegated by either primary responsible agency to the other with the concurrence of both in the interests of program efficiency.

c. In the event an SWS treatment program requires intervention by the Court, CPS, working with the County Attorney, will seek appropriate judicial remedies, including any necessary modifications to the existing treatment program and will assume primary responsibility for the implementation of any subsequent court-ordered treatment plan.

9. Records Access. Access to military records needed by (Simpson) County authorities for the investigation, processing, treatment or prosecution of child abuse cases will be made available by the appropriate records custodian according to applicable law and regulations. Request for records should be made through the Chief, SWS, who in turn will arrange for the release of necessary information.

10. Reports. CPS will make monthly reports to the CRC on the status of all open cases.

11. Communications. Effective execution of this agreement can only be achieved through constant communication and through dialogue among and between the parties. It is, therefore, the policy of the members of this agreement that access to all parties will remain open and that the resulting channels of communication will be used whenever questions, misunderstandings or complaints arise.

12. Cooperation. The Commanding General, Fort (Green) will ensure the cooperation of all Fort (Green) officials with (Simpson) County representatives. The Commanding General will further direct that an installation memorandum of agreement be executed which establishes standard operating procedures among installation agencies in accordance with this Memorandum of Agreement.

Presiding Judge
(Simpson) County
State of (Kansas)

County District Attorney
(Simpson) County
State of (Kansas)

Director, (Simpson) County
Department of Child Protective Services

Major General, USA
Commanding
Fort (Green, Kansas)

Figure C-1. Sample format for a Memorandum of Agreement

Appendix D
Legal and Jurisdictional Considerations

D–1. Types of legislative jurisdiction

In the United States, there are generally three types of legislative jurisdiction existing on Army installations. Some installations have different types of legislative jurisdiction applying to different geographical areas of the installation. These three types are-

a. Exclusive Federal Legislative Jurisdiction.This exists in situations where the federal government has all of the authority that the state would otherwise have to legislate within the land area in question. The state usually reserves the right to serve judicial process on the installation for acts or omissions occurring off the installation, but generally the state can exercise no authority over the installation. However, state criminal laws apply to those on the installation, not as violations of state law, but rather, as violations of federal law under the Assimilative Crimes Act (18 U.S.C. Section 13).Prosecution can occur in either a federal district court or federal magistrate court, or under the UCMJ (if the accused is military) and the decision whether or not to prosecute is made by federal, not state officials.State civil laws generally apply to persons on the installation, but those state civil laws requiring enforcement by state officials (e.g., child protection laws) only apply to the extent that federal laws and military regulations do not conflict with state law (see para D-2), and the installation commander invites the state authorities, by agreement or otherwise, to exercise their authority on the installation. Most Army installations in the United States are under exclusive federal legislative jurisdiction.

b. Concurrent legislative jurisdiction. This exists in situations where the state and federal government exercise concurrently all of their legislative jurisdiction over the land area in question. State criminal and civil laws apply to those on the installation and, to the extent that there is no interference with the federal function or military mission (see para D-2), may be enforced by state officials in state courts. Federal officials may also exercise the same authority that may be exercised on installations under exclusive Federal legislative jurisdiction.

c. Proprietary interest. This exists in situations where the federal government, by lease, easement, purchase, or similar method, has acquired some degree of ownership or right to use the land area or buildings in question, but has not obtained any legislative authority over the land by virtue of that acquisition. As with concurrent legislative jurisdiction, state criminal and civil laws apply to those on the installation. The Assimilative Crimes Act does not apply, and violations of state law may only be enforced in state courts. As with other types of legislative jurisdiction, criminal acts by soldiers may be punished under the UCMJ.

D–2. Federal supremacy

a. The United States Constitution, Article VI provides that the"-Constitution, and the Laws of the United States which shall be made in Pursuance thereof ... shall be the Supreme Law of the Land, and the Judges in every state shall be bound thereby, anything in the Constitution or Laws of any State to the Contrary notwithstanding."

b. Regardless of the type of legislative jurisdiction involved, military personnel generally are not subject to state criminal laws or civil laws (i.e., liability for civil damages) for acts done within the scope of their duties, whether occurring on or off the installation because of the so-called "federal supremacy" doctrine.

c. The federal supremacy doctrine does not protect commanders and military personnel from the application of state criminal and civil laws for acts done outside the scope of their military duties, and affords no protection to family members or other civilians residing on or visiting the installation.

Appendix E
Privileged Communications

E–1. General

a. A claim of a privilege includes, but is not limited to, the assertion by a person of a privilege to refuse to be a witness in a criminal or civil proceeding, to refuse to disclose any information, to refuse to produce any object or writing, or to prevent another from being a witness or disclosing any information or producing any object or writing. (See M.R.E.501(b), MCM)

b. The law of the forum (e.g., the court or board) determines the application of a privilege. Within the Army, the protection afforded privileged communications is determined by applicable federal law, military regulations and Executive Orders (e.g., MCM and AR 165-1). Within state or foreign courts, the existence or scope of a privilege, even for military lawyers or chaplains testifying in those courts, is determined by applicable state or foreign law.

c. Generally, the purpose of a privilege is to protect the confidentiality of communications made by those seeking help or counseling, not to suppress evidence of crime or to protect people in trouble.

E–2. Communications to physicians

There is no physician-patient privilege in the military. Even if a soldier consults with a private physician in a jurisdiction with a doctor-patient privilege, such a privilege is inapplicable to a court-martial or other military proceeding or investigation.

E–3. Communications to social workers and psychologists

There is no social worker-client privilege in the military.

E–4. Lawyer-client privilege

In the military, a client has a privilege to refuse to disclose and to prevent any other person from disclosing confidential communications made for the purpose of receiving professional legal advice. A military lawyer has no obligation to make a report of spouse or child abuse that comes to his or her attention as result of a privileged communication unless the communication clearly contemplates the commission of a future crime. (See M.R.E. 502, MCM.)Acting within his or her discretion, an attorney advising a client who is a victim or perpetrator of spouse or child abuse can encourage that person to make a report of such abuse or to seek treatment, as appropriate.

E–5. Communications to clergy

In the military, a person has a privilege to refuse to disclose and to prevent another from disclosing a confidential communication by the person to a clergyman if such communication is made either as a formal act of religion or as a matter of conscience.(M.R.E. 503, MCM and AR 165–1, para 1-6). A uniformed or civilian member of the clergy working for the military has no obligation to make a report of spouse or child abuse that comes to his or her attention as a result of a privileged communication. Acting within his or her discretion, a member of the clergy may encourage a person who is a victim or perpetrator of spouse or child abuse to make a report of such abuse or to seek treatment, as appropriate.

Glossary

Section I
Abbreviations

ACS
Army Community Service

ACSIM
Assistant Chief of Staff for Installation Management

ADCO
Alcohol and Drug Control Officer

APF
Appropriated Funds

ARNG
Army National Guard

CDS
Child Development Services

CHN
Community Health Nurse

CMHA
Community Mental Health Activity

CPS
Child Protective Services

CRC
Case Review Committee

DA
Department of the Army

DCSPER
Deputy Chief of Staff for Personnel

DENTAC
Dental Activity

DIC
Deputy Installation Commander

DOD
Department of Defense

DODDS
Department of Defense Dependent School System

DDESS
Department of Defense Dependent Elementary and Secondary Schools (Formerly Section 6 Schools)

DPCA
Director of Personnel and Community Activities

ETS
Estimated Time of Separation

FAC
Family Advocacy Committee

FACAT
Family Advocacy Command Assistance Team

FAP
Family Advocacy Program

FAPM
Family Advocacy Program Manager

FAST
Family Advocacy Staff Training

FCC
Family Child Care

HQDA
Headquarters, Department of the Army

MACOM
Major Army Command

MCM
Manual for Courts-Martial, United States, 1984

MEDDAC
Medical Department

MOA
Memorandum of Agreement

MPRJ
Military Personnel Records Jacket

M.R.E
Military Rule of Evidence

MTF
Medical Treatment Facility

MWR
Morale, Welfare and Recreation

NAF
Nonappropriated Funds

NAFI
Nonappropriated Funds Instrumentality

OALE
Office of Army Law Enforcement

ODCSPER
Office of the Deputy Chief of Staff for Personnel

OMPF
Official Military Personnel File

OTJAG
Office of the Judge Advocate General

OTR
Official Treatment Record

OTSG
Office of the Surgeon General

PAD
Patient Administration Division

PAO
Patient Affairs Officer

PASBA
U.S. Army Patient Administrative Systems and Biostatistics Activity

PCS
Permanent Change in Station

PET
Parent Effectiveness Training

PM
Provost Marshal

R.C.M.
Rule for Courts-Martial

RPOC
Report Point of Contact

SCHR
State Criminal History Repository

SIR
Serious Incident Report

SJA
Staff Judge Advocate

SOP
Standing Operating Procedure

SSN
Social Security Number

STEP
Systematic Training for Effective Parenting

SWS
Social Work Service

TAG
The Adjutant General

TJAG
The Judge Advocate General

TRADOC
U.S. Army Training and Doctrine Command

TSG
The Surgeon General

UCMJ
Uniform Code of Military Justice

USACFSC
U.S. Army Community and Family Support Center

USACIDC
U.S. Army Criminal Investigation Command

USAF
U.S. Air Force

USAR
U.S. Army Reserve

USAREC
U.S. Army Recruiting Command

USCG
U.S. Coast Guard

USMC
U.S. Marine Corps

USN
U.S. Navy

YS
Youth Services

Section II
Terms

Abuser
A person who abuses children or his or her spouse.

Army Central Registry
An Army-wide index of abuse reports.

At-risk
A situation involving an individual who is vulnerable to spouse or child abuse but where no abuse has occurred. Characteristics that may place children at increased risk for abuse and neglect include premature birth of a child to adolescent parents; the presence of an infant with colic accompanied by continuous crying, congenital deficiencies or abnormalities; extreme financial distress; substance abuse; or any other condition that interferes with parent-child attachment.

Case Management
The process of coordinating health and social services so that the client receives the most appropriate care in a timely, efficient manner.

Case Manager
The individual who coordinates all of the health, social and other services on behalf of the client or group of clients, and monitors the progress of clients through the sequence of the treatment program.

Child
An unmarried minor, whether a biological child, adopted child, foster child, stepchild, or ward of a military member or a civilian for whom treatment is authorized in a medical facility of the Military Services, who is under the age of 18 years or is incapable of self-support because of a mental or physical incapacity.

Child physical abuse
A type of maltreatment that refers to physical acts that caused or may have caused physical injury to the victim. Includes injuries to a child such as brain damage or skull fracture, subdural hemorrhage or hematoma, bone fracture, shaking or twisting of infants and young children, dislocations or sprains, internal injury, poisoning, burns or scalds, severe cuts, lacerations, bruises or welts; or other physical injury that seriously impairs the health or physical well-being of the victim. Minor injuries include cuts, bruises or welts; or other shaking or twisting incidents that do not result in injury that impairs the health or physical well-being of the victim.

Child protective services
Any state, local or foreign department, agency or office that provides child protective services to families affected by child abuse.

Child sexual abuse
The employment, use, persuasion, inducement, enticement, or coercion of any child to engage in, or having a child assist any other person to engage in, any sexually explicit conduct (or any simulation of such conduct) or the rape, molestation, prostitution, or other such forms of sexual exploitation of children, or incest with children. All sexual activity between an offender, male or female, regardless of age, and a child, when the offender is in a position of power over the child whether in a caretaker role or not, is considered sexual abuse. The child victim should be considered for appropriate FAP services, if eligible. Sexual maltreatment specifically includes but is not necessarily limited to the following: (State law may provide additional grounds).

a. Exploitation: Forcing a child to look at an offender's genitals, forcing a child to observe an offender's masturbatory activities, exposing of a child's genitals for gratification of the offender(s) sexual desires, talking to a child in a sexually explicit manner, surreptitious viewing of a child while undressed for the offender(s) sexual gratification, or involving a child in sexual activity such as pornography or prostitution in which the offender does not have direct physical contact with the child.

b. Rape: Generally, any act of sexual intercourse between an offender and a female, committed by force and without consent. Any penetration of the vagina, however slight, constitutes rape when done by force and without consent. Children of tender years who are not capable of understanding the nature of the act are not capable of giving consent. Force may be physical, mental coercion, or emotional manipulation.

c. Carnal Knowledge: Sexual intercourse under circumstances not amounting to rape between an offender and a child who has not attained the legal age of consent (age 16 under the UCMJ). Any vaginal penetration, however slight, is sufficient to complete the offense. Ignorance of the child's age is not a defense.

d. Sodomy: Unnatural carnal copulation with another person of the same or opposite sex or with an animal. It is unnatural carnal copulation for a person to take into that person's mouth or anus the sexual organ of another person or of an animal; or to place that person's sexual organ in the mouth or anus of another person or of an animal. Sodomy may be either consensual or forcible. Any penetration, however slight, is sufficient to complete the offense.

e. Molestation/Indecent Acts: May include fondling or stroking of breasts or genitals, or attempted penetration of the child's vagina or rectum, either digitally or with an object.

f. Incest: Sexually explicit activity identified above between a child and biological parent, step-parent, adoptive parent, a sibling, or other relative too closely related to be permitted by law to marry. Sexual abuse by familial caretakers (i.e. other live-in guardians) may sometimes be viewed clinically as incest depending on the specifics of the case.

g. Other sexual maltreatment: Other sexual activity with a child, including encouraging another to engage in any of the above activities, encouraging or observing masturbation, taking sexually explicit photographs of a child, etc. May also include acting as a principal or accessory after the fact in any of the above listed activities.

Defense counsel
Army lawyers assigned to the U.S. Army Trial Defense Service, as well as any other lawyer hired by, retained by, or detailed to a soldier or family member to defend him or her on a criminal charge or on an adverse military administrative personnel action.

Department of Defense operated or sanctioned activity
May be either a non-governmental activity or activity operated by U.S.Government employees that is involved in the care of children. The care of children may be either its primary or incidental mission in carrying out another mission. Examples include Child Development Services, Youth Services, child care activities provided as part of Chaplain's programs or as part of another Morale, Welfare or Recreation program, Family Child Care, contracted child care services provided by private organizations, and Boy/Girl Scouts.

Emotional Abuse
Emotional abuse involves a pattern of active, intentional berating, disparaging, or other abusive behavior toward the victim that may not cause observable injury. Emotional neglect involves passive or passive-aggressive inattention to the victim's emotional needs, nurturing, or psychological well-being.

Extrafamilial abuse
This category is applicable in cases of child abuse where the offender has no family relationship to the child. This may range from individuals who are known to the victim to those who are not, and many include individuals living or visiting in the same residence who are unrelated to the victim by blood or marriage, and who are not cohabiting with the child's parent. This also includes individuals having out-of-home-care supervision of the child, such as school, child or family care personnel, volunteers or other DOD sanctioned or operated activities such as:

(1) Child care centers. Child development

or child care services, nursery schools, preschools, or parent co-ops provided in a centralized facility. This does not include home-based child care.

(2) Family child care. Home-based child care provided on a regular or daily basis for compensation. This does not include an individual offering random, temporary baby-sitting service.

(3) School Personnel. Any staff member or volunteer in a public orprivate school.

(4) Youth Personnel. Any staff member or volunteer in a DOD sponsored or sanctioned program, service or activity focused on youth, including but not limited to recreation, camps, scouting, clubs and classes (outside the school system).

Family member
An individual whose relationship to the sponsor authorizes entitlement to treatment in a medical facility of the Military Services.

Foster care
A voluntary or court-mandated program that provides 24-hour care and supportive services in a family home or group facility for children who cannot be properly cared for by their own families.

Foster child
A child other than the sponsor's child who resides in the sponsor's home whose care, comfort, education, and upbringing have been entrusted to the sponsor by a court or a civilian agency or by a parent of the child on a temporary or permanent basis. A foster child also includes a sponsor's child who has been placed in foster care by a local civilian authority.

Guardian ad litem
A guardian appointed by a court to represent the interests of a child in a child protective case. A guardian ad litem is considered an extension of the court and helps the court decide what is in the best interests of the child.The guardian ad litem may request evaluation and tests of the parents and child to assist in the guardian's recommendations to the court.

Installation
A grouping of facilities, located in the same vicinity, which support particular functions. Land and improvements permanently affixed there to which are under the control of the Department of the Army and used by Army organizations. A military community in foreign countries may be equivalent to an installation.

Legal assistance attorneys
Army lawyers who advise and assist soldiers and their families on family law matters. Such matters include marriage, divorce, adoption, paternity, child custody problems, and financial support obligations. In the context of this regulation, a legal assistance attorney also includes a lawyer retained by a soldier or family member at his or her own expense to handle such legal matters.

Medical protective custody
Emergency medical care or custody of a child without parental consent that is approved by a medical treatment facility commander in cases where the circumstances or condition of the child are such that continuing the child in the care or custody of the parents presents imminent danger to the child's life or health.

Out-of-home child abuse
Child abuse that occurs in a DoD operated or sanctioned activity. The abuser has a caretaking responsibility or is another adult or child who is commonly present in that environment (e.g., custodial staff).

Outreach
A method of providing social services by reaching out to potential consumers rather than waiting for them to request assistance.

Parent
The father or mother of a child related by blood, a father or mother by marriage (stepparent), a father or mother of an adopted child (adoptive parent), a guardian, or any other person charged with a parent's rights, duties, and responsibilities.

Report point of contact
The person or location on the installation designed to receive all reports of spouse and child abuse and to notify the appropriate authorities with regard to such reports.

Spouse Abuse
a. Physical Spouse Abuse

(1) Use of physical force that caused physical injury to the spouse.Violence generally used to intimidate, control, or force the spouse to do something against his or her will. This may include grabbing, pushing, holding, slapping, choking, punching, sitting or standing on, kicking, hitting with objects, and assaulting with knives, firearms or other weapons.

(2) The forcing of one spouse by the other spouse to engage in any sexual activity through the use of physical violence, intimidation, or the explicit or implicit threat of future violence.

b. Emotional Spouse Abuse.
A pattern of acts or omissions, such as violent acts that may not cause observable injury, that adversely affect the psychological well-being of the victim. Arguments alone are not sufficient to substantiate emotional maltreatment.

(1) Psychological violence is a pattern of behavior involving one or more of the following behaviors: explicit or implicit threats of violence, extremely controlling types of behavior, extreme jealously, mental degradation (name calling, etc.), and isolating behavior.

(2) Property violence by one spouse may constitute emotional abuse if intended as a means to intimidate the other spouse. Property violence includes, but is not limited to, damaging or destroying the other spouses property, hitting/kicking a door or wall, throwing food, breaking dishes, and intentionally or recklessly damaging automobiles. Threatening injury to or injuring pets is included in this category.

Sponsor
An active duty military member or employee of the Department of Defense who is authorized treatment in a medical facility of the military services.

State Criminal History Repository (SCHR) (see DA Circular 690–95–1)
The state's central record of investigative files. State information, including addresses, phone numbers, costs and remarks. (DA Form 7215–R/DA Form 7215–R–E) (Release/Consent Statement)

Staff Judge Advocate (see RMC 103(17))
A judge advocate so designated in the Army, Air Force or Marine Corps; the principal legal advisor of a command in the Navy and Coast Guard who is a judge advocate. The SJA advises the commander on laws and regulations affecting the command. Does not include a attorneys assigned to the U.S.Army Trial Defense Service.

Substantiated case
A case that has been fully investigated for which the preponderance of the available information indicates that abuse occurred. Refer to para 2-d.

System of records - (see AR 340–21 (Glossary))
A group of records under U.S. Government control from which information is retrieved by the name of the individual or by some identifying number, symbol, or other identifying particular assigned to the individual.

Unit commander
The immediate officer-in-charge or in a position of command, who has control over persons subject to military law.

Unsubstantiated case
A case of abuse that has been fully investigated for which the available information is insufficient to substantiate that abuse occurred.

Withholding medically indicated treatment
The failure to respond to the infant's or child's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will most likely be effective in ameliorating or correcting all such conditions. However, the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant when, in the treating physician's or physicians'reasonable medical

judgment:

a. The infant is chronically and irreversibly comatose;

b. The provision of such treatment would

(1) merely prolong dying,

(2) not be effective in ameliorating or correcting all of the infant's life-threatening conditions, or

(3) otherwise be futile in terms of the survival of the infant; or

c. the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

Ward
A child (other than the sponsor's child) or adult who resides in the sponsor's home whose care has been entrusted by a court (or voluntarily assumed by the sponsor) because of age, or a physical, mental, or emotional disability.

Youthful Sex Offenders
A child under the age of 18 years who commits any act of sexual abuse against any person, including another minor child, either against the victim's will, through coercion or trickery, fraud, or in an exploitative or threatening manner. Sexual abuse generally may include, but is not limited to the acts described under the definition of Child Sexual Abuse, even when applied to an adult. Children of tender years who are not capable of understanding the nature of the act cannot consent.

Section III
Special Abbreviations and Terms
There are no entries in this section.

Index

This index is organized alphabetically by topic and by subtopic within a topic. Topics and subtopics are identified by paragraph number.

CHILD ABUSE/SAFETY VIOLATION HOTLINE INTAKE INFORMATION

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

PRINCIPAL PURPOSE: To identify and record information on reports of child and spouse abuse and provide protection and medical treatment to military members and their families.

ROUTINE USES: The military services use the information for internal management and maintain it by service. Data forwarded to OSD will be aggregated for analysis and void of case identifiers. Incident data is used to evaluate and identify protocols required in the case. Service program managers use the data to identify incidence and prevalence rates and trends; track involved families; justify appropriate resource allocation; and review and control providers of care.

DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. DATE OF CALL	2. INSTALLATION	3. MACOM	4. DOD CASE NUMBER

5. INTAKE RECEIVED BY	6. FACILITY *(Include CDC, YS Building Number/FCC Provider Name and Address)*

7. TYPE INCIDENT				7.c. ACTIVITY *(e.g., CDC, FCC, YS)*	
7.a. SAFETY		7.b. CHILD ABUSE		7.d. SETTING	
	FIRE		PHYSICAL		ACTIVITY ROOM
	HEALTH		SEXUAL		BATHROOM
	FACILITY		EMOTIONAL		OFFICE
	GENERAL		NEGLECT		YARD
8. DATE OF INCIDENT/DATE VIOLATION NOTICED					KITCHEN
					BEDROOM
					PUBLIC LIVING AREA
					SPORTS FIELD/FACILITY
					OTHER *(Specify)*

9. DESCRIPTION OF INCIDENT *(If additional space is needed, continue on separate sheet.)*

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10. VICTIM(s) INFORMATION *(If additional space is needed, continue on separate sheet)*				
a. NO.	b. AGE	c. SEX OF VICTIMS	d. TYPE OF ABUSE *(Physical, Sexual or Neglect)*	e. GRADE/RANK/MILITARY OR CIVILIAN STATUS OF EACH VICTIM'S SPONSOR
1				
2				
3				
4				

11. PREVIOUSLY REPORTED BY CALLER TO *(Enter date reported)*			
DATE REPORTED		DATE REPORTED	
	CDS		MILITARY POLICE
	CPS		CIVILIAN POLICE/FBI
	FAP		INSTALLATION COMMANDER
	CRIMINAL INVESTIGATORS		SAFETY OFFICE
	MEDICAL		OTHER *(Specify)*
	YS		

12.a. SUSPECT NAME	12.b. SUSPECT AGE	12.c. SUSPECT SEX
12.d. SUSPECT GRADE/RANK AND MILITARY/CIVILIAN STATUS	12.e. SUSPECT BRANCH OF SERVICE AND COMMAND IF ACTIVE DUTY	

12.f. SUSPECT POSITION					
	PROVIDER		PARENT		CONTRACT EMPLOYEE
	CAREGIVER		ADMINISTRATOR		FAMILY MEMBER
	SUPPORT STAFF		COACH		OTHER *(Specify)*
	VOLUNTEER		RECREATION AIDE		

13.a. REPORTER NAME *(Optional)*	13.b. REPORTER ADDRESS *(Optional)*	13.c. PHONE NUMBER *(Optional)*

HQDA USE ONLY		
14. CALL REFERRED TO	15. 7-DAY REPORT DUE	16. 90-DAY REPORT DUE
17. HQDA FAP POC	18. ENTERED IN DATABASE BY	
19. DATE ENTERED IN DATABASE	20. HQDA CASE NO.	

CHILD ABUSE/SAFETY VIOLATION HOTLINE 7-DAY FOLLOW-UP INFORMATION

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

PRINCIPAL PURPOSE: To identify and record information on reports of child and spouse abuse and provide protection and medical treatment to military members and their families.

ROUTINE USES: The military services use the information for internal management and maintain it by service. Data forwarded to OSD will be aggregated for analysis and void of case identifiers. Incident data is used to evaluate and identify protocols required in the case. Service program managers use the data to identify incidence and prevalence rates and trends; track involved families; justify appropriate resource allocation; and review and control providers of care.

DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. DATE OF CALL	2. INSTALLATION	
3. MACOM	4. DOD CASE NUMBER	5. DATE OF DOD HOTLINE CALL

6. NAME AND TITLE OF CALLER	7. FACILITY *(Include CDC or YS Building Number/FCC Provider Name and Address)*
8. TYPE INCIDENT	9. POTENTIAL FOR PUBLICITY

If additional space is needed for items 10 thru 14, continue on separate sheet.

10. PRELIMINARY FINDINGS *(If applicable)*

11. ACTIONS TAKEN BY FAP *(CRC, SWS)*

12. ACTIONS TAKEN BY ACTIVITY *(e.g., CDS, YS)*

13. ACTIONS TAKEN BY LAW ENFORCEMENT/CID

14. ACTIONS TAKEN BY COMMAND *(If applicable)*

15. ALLEGED OFFENDER STATUS			
	REASSIGNED WITHOUT CHILDREN		ARRESTED
	REMAINS		INDICTED
	SEPARATED		REINSTATED

16. PLAN OF ACTION FOR INVESTIGATION

HQDA USE ONLY

17. HQDA CASE NUMBER	18. DATE FORWARDED TO DOD
19. RECEIVED AT DOD BY	20. DATE ENTERED IN DATABASE

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CHILD ABUSE/SAFETY VIOLATION HOTLINE 90-DAY FOLLOW-UP INFORMATION

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

PRINCIPAL PURPOSE: To identify and record information on reports of child and spouse abuse and provide protection and medical treatment to military members and their families.

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DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. DATE OF CALL	2. INSTALLATION	3. MACOM
4. DOD CASE NUMBER	5. DATE OF DOD CALL TO HQDA	6. TYPE OF INCIDENT

7. FACILITY *(Include CDC or YS Building Number/FCC Provider Name and Address)*

8. CRC DETERMINATION	9. DATE OF DETERMINATION

10. IS/ARE VICTIM*(s)* RECEIVING TREATMENT?	11. IS SUSPECT RECEIVING TREATMENT?

12. VICTIM*(s)* INFORMATION *(If additional space is needed, continue on separate sheet)*

a. NO.	b. AGE	c. SEX OF VICTIMS	d. TYPE OF ABUSE *(Physical, Sexual or Neglect)*	e. GRADE/RANK/MILITARY OR CIVILIAN STATUS OF EACH VICTIM'S SPONSOR
1				
2				
3				
4				

13. SUSPECT INFORMATION

a. NAME OF SUSPECT	b. AGE	c. SEX
d. POSITION		e. GRADE/RANK
f. STATUS *(Active duty, Reserve, Civilian, Contract, Volunteer, Other)*	g. BRANCH OF SERVICE IF ACTIVE DUTY	

14. SUSPECT SITUATION		15. FCC HOME SITUATION	
	SEPARATED FROM SERVICE/POSITION		OPEN
	REMAINS IN POSITION		CLOSED TEMPORARILY
	TRANSFERRED FROM CHILD CONTACT		CLOSED PERMANENTLY

HQDA USE ONLY

16. ENTERED IN DATABASE BY	17. DATE

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INITIAL REPORT OF CHILD ABUSE IN DOD OPERATED OR SANCTIONED ACTIVITIES

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

PRINCIPAL PURPOSE: To identify and record information on reports of child and spouse abuse and provide protection and medical treatment to military members and their families.

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DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. NAME AND TELEPHONE NUMBER OF PERSON TO BE CONTACTED FOR ADDITIONAL INFORMATION	2. INSTALLATION
3. MACOM	4. DATE AND TIME ALLEGED INCIDENT OCCURRED
5. TYPE OF CHILD ABUSE ☐ SEXUAL ☐ PHYSICAL ☐ NEGLECT	6. ACTIVITY AND LOCATION OF ALLEGED ABUSE

7. VICTIM*(s)* INFORMATION (*If additional space is needed, continue on separate sheet)*

a. NO.	b. AGE	c. SEX OF VICTIMS	d. TYPE OF ABUSE *(Physical, Sexual or Neglect)*	e. GRADE/RANK/MILITARY OR CIVILIAN STATUS OF EACH VICTIM'S SPONSOR
1				
2				
3				
4				

8. DESCRIPTION OF ALLEGED OFFENDER

a. POSITION/RELATIONSHIP, IF ANY, WITHIN ACTIVITY *(e.g., CDS Center Teacher, Volunteer, FCC Provider, FCC Family Member)*	b. SEX	c. AGE
d. DATE HIRED/CERTIFIED	e. DATE BACKGROUND CHECKS CONDUCTED AND RESULTS	

9. DESCRIPTION OF INCIDENT (*If additional space is needed, continue on separate sheet)*

10. DATE REPORTED TO INSTALLATION RPOC	11. DATE REPORTED TO MILITARY LAW ENFORCEMENT
12. DATE REPORTED TO FAMILY ADVOCACY PROGRAM MANAGER	13. DATE REPORTED TO CHILD PROTECTIVE SERVICES, IF APPLICABLE
14.a. DATE REPORTED TO MACOM	14.b. DATE REPORTED TO DA

15. OFFICIALS/AGENCIES CONDUCTING INVESTIGATION

16. CURRENT STATUS OF INVESTIGATIONS

17. ALLEGED OFFENDER STATUS			
☐	REASSIGNED WITHOUT CHILDREN	☐	CONFINED
☐	REMAINS ON JOB	☐	ARRESTED
☐	TERMINATED	☐	INDICTED
		☐	REINSTATED

18. CORRECTIVE ACTIONS INITIATED

19. POTENTIAL FOR PUBLICITY

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FOLLOW-UP/INTERIM REPORT OF CHILD ABUSE IN DOD OPERATED OR SANCTIONED ACTIVITIES

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

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DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. DATE OF REPORT	2. INSTALLATION
3. REPORTED BY	4. REPORTED TO
5. ACTIVITY	6. TYPE OF ABUSE

7. STATUS OF SUSPECT

	REASSIGNED		CONFINED
	REINSTATED		ARRESTED
	TERMINATED		INDICTED
	RESIGNED		OTHER *(Specify)*

8. VICTIM*(s)* INFORMATION *(If additional space is needed, continue on separate sheet)*

a. NO.	b. AGE	c. SEX OF VICTIMS	d. TYPE OF ABUSE *(Physical, Sexual or Neglect)*
1			
2			
3			
4			

9. MEDIA INTEREST *(Attach articles if available)*

10. PARENTAL CONCERN/LAWSUIT

11. MEDICAL FINDING*(s)* PER VICTIM

12. ADMINISTRATIVE LEGAL ACTIONS PENDING

13. CRC DECISION	14. DATE OF CRC DECISION

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CLOSE OUT REPORT FOR REPORTS OF CHILD ABUSE IN DOD OPERATED OR SANCTIONED ACTIVITIES

For use of this form, see AR 608-18; the proponent agency is OACSIM

AUTHORITY: PL 93-247, Child Abuse Prevention and Treatment Act of 1974, DoD Directives 6400.1, 6400.2 and 6400.3 Family Advocacy Program

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DISCLOSURE: Disclosure is voluntary; however, failure to provide information may delay the provision of appropriate services to the individual.

1. NAME OF INSTALLATION	2. MACOM
3. ACTIVITY	4. DATE OF ORIGINAL REPORT

5. TYPE OF CHILD ABUSE		6.a. CRC DETERMINATION	
	SEXUAL		UNSUBSTANTIATED
	PHYSICAL		SUBSTANTIATED
	NEGLECT	b. DATE OF CRC DETERMINATION	

7. VICTIM*(s)* INFORMATION *(If additional space is needed, continue on separate sheet)*

a. NO.	b. AGE	c. SEX OF VICTIM*(s)*	d. TYPE OF ABUSE *(Physical, Sexual or Neglect)*
1			
2			
3			
4			

8. SUMMARY OF LEGAL ACTIONS THAT HAVE OCCURRED *(e.g., employee disciplinary measures, prosecution)*

9. LESSONS LEARNED, INCLUDING RECOMMENDATIONS FOR CHANGES IN ARMY OR MACOM POLICY

10. CORRECTIVE ACTIONS COMPLETED OR PROGRAMMED

HQDA USE ONLY

11. ENTERED IN DATABASE BY	12. DATE

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DOC STATUS: NEW PUBLICATION